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THE UNIVERSITY OF ALBERTA

ADOLESCENT SUICIDE: THEORETICAL AND CLINICAL ASPECTS

by

© SUSAN EDITH COCHRANE

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF EDUCATION

IN

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled ADOLESCENT SUICIDE: THEORETICAL AND CLINICAL ASPECTS submitted by SUSAN EDITH COCHRANE in partial fulfilment of the requirements for the degree of Master of Education.

....
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Allen T Pearce..............................

J Mitchell..............................

Date ....June 23, 1980.

DEDICATION

To

Doug,

who inspired this book.

PREFACE

Adolescent suicide is one of the last taboo topics in our society. It is distasteful to think that a young person at the peak of health and energy should wish to kill himself. Repression and denial enable us to believe that youth do not have such problems.

The shroud of uneasiness which cloaks adolescent suicide means that suicidal adolescents receive little recognition of their problems other than cries of "I never thought he'd really do it," after the tragic act. No amount of shock and surprise will aid the growing numbers of adolescents who are killing themselves.

The refusal to acknowledge adolescent suicide has also resulted in a scarcity of books on the subject. Very little is known about the phenomenon, and those wanting to learn more are frustrated by lack of cooperation and information. Consequently, those who work with adolescents are prepared in university training programs with no knowledge, or skills, for dealing with suicidal students they will certainly encounter in their future careers.

This book is an attempt to gather the sparse and widely scattered data available on the subject of adolescent suicide. In this manner, the information will be readily available to students in the helping professions, and those responsible for their training. It is especially hoped that school psychologists and counsellors will find the book useful, for these are the professionals with the greatest responsibility for identifying, treating, or referring suicidal adolescents in high schools.

The scope of this book is intentionally broad because it is one of the few sources available on the subject. The reader can expect information on a wide variety of topics, including statistics, explanatory theories, intervention techniques, and prevention of adolescent suicide.

The information in this book will be organized into three major sections. The first section is comprised of two chapters which discuss actual numbers of adolescents who commit suicide and statistical trends of suicide. Various kinds of suicidal behavior will also be defined and discussed. Part two of the book examines why adolescents commit suicide. Sociological, psychological, and psychosocial theories are discussed to provide the reader with an understanding of what dynamics cause an adolescent to consider suicide. The final portion of the book explains what to do about adolescent suicide. Topics include identifying, treating, and preventing adolescent suicides. There will also be some discussion of aiding the often neglected survivor-victims of suicide.

Something can, and must, be done to help suicidal adolescents. To do this, we must first gather information and knowledge, and then disseminate this to those who must deal with adolescents. The following chapters are a tentative step in this direction. It is hoped they will inspire others to begin research and writing on a long neglected subject.

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To Dr. Henry Janzen, for his guidance, encouragement, and unfailing support throughout this project.

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TABLE OF CONTENTS

PAGE

DEDICATION iv

PREFACE v

ACKNOWLEDGEMENTS viii

TABLE OF CONTENTS ix

LIST OF TABLES xiii

LIST OF FIGURES xiv

PART ONE

DEFINING ADOLESCENT SUICIDE

CHAPTER

1 THE STATISTICS OF SUICIDE 2

2 SUICIDE: DEFINING THE CONCEPT 13

Orientations Toward Death 18

Suicidal Behavior of Adolescents 24

PART TWO

EXPLANATIONS OF ADOLESCENT SUICIDE

3 SOCIOLOGICAL THEORIES OF SUICIDE 33

4 PSYCHOLOGICAL EXPLANATIONS OF SUICIDE 43

Psychoanalytic Explanations of Suicide. 45

The Neo-Freudian Approach 50

CHAPTER PAGE

The Existential View of Suicide . . . 55

A Developmental Theory of Adolescent Suicide 61

5 AN INTERACTIONAL THEORY OF ADOLESCENT SUICIDE. 76

6 PERSONALITY FACTORS ASSOCIATED WITH ADOLESCENT SUICIDE 104

Hostility 105

Dependence 106

Anxiety 107

Social Isolation and Antisociality . 108

Impulsiveness 109

Self Concept 109

Approach to Problem Solving 110

Intelligence 112

Value Orientation 113

Mental Health 113

Locus of Control 115

7 THE FAMILY AND SUICIDE 125

Characteristics of Suicidal Families. 126

Communication Dynamics of Suicidal Families. 133

A Final Word About Suicidal Families. 142

PART THREE

WHAT TO DO ABOUT ADOLESCENT SUICIDE

8 THE PREDICTION OF ADOLESCENT SUICIDE . . . 152

CHAPTER PAGE

Demographic Predictors of Suicide 154

Psychological Predictors of Suicide . 154

Clinical and Evaluative Prediction of Suicide 162

Psychological Test Prediction of Suicide Risk 165

9 INTERVENING IN SUICIDE 183

General Orientations Toward Therapy . 190

General Approaches to Suicide Therapy 198

10 SPECIFIC INTERVENTION TECHNIQUES 206

Crisis Intervention 207

Family Therapy 215

Environmental Manipulation and Follow-up Care 221

Group Therapy 224

Pharmacotherapy 225

11 TREATING THE SURVIVOR-VICTIMS OF SUICIDE. 233

Survivor Defences 235

Survivor-Victim Reactions to Suicide and Suicide Attempts 236

General Principles Underlying Survivor-Victim Therapy 242

Phases of Survivor-Victim Therapy . . 244

Future Directions for Survivor-Victim Therapy 245

Survivor Victims in the School . . . 246

CHAPTER PAGE

12 THE PREVENTION OF SUICIDE 253

Suicide Prevention Centers 255

Follow-up and Outreach Programs . . 257

Suicide Prevention in the Community 260

Suicide Research 265

Suicide Prevention in the Schools. . 271

REFERENCES 282

LIST OF TABLES

Table Page

One: Predictors of Suicide Lethality 173

Two: The Hopelessness Scale 176

LIST OF FIGURES

Figure Page

One The Continuum of Suicidal Behaviors 27

Two Intent Versus Outcome 28

PART ONE

DEFINING ADOLESCENT SUICIDE

CHAPTER 1

THE STATISTICS OF SUICIDE

By the time you finish reading this page, one or more persons in the United States will have tried to kill themselves.[1] At this time tomorrow, at least sixty people in the U.S.A. will have taken their own lives and many in Canada will have died the same way.[2] Even more disquieting is the likelihood that these statistics are only the tip of the iceberg because suicide is greatly under-reported. Add to this the number of traumatized survivors that each suicide leaves behind, and we discover a pervasive and alarming problem that affects more lives than we can imagine.

Suicide is no respecter of race, religion, color, age, or socioeconomic status. All are affected! In 1979, 10,000 Canadians tried to kill themselves, and 1000 of these persons were adolescents.[3] It is estimated that the real rate of adolescent suicide deaths could be twenty-five to one-hundred times this figure.[4] This would mean that as many as 100,000 Canadian adolescents may be attempting suicide per year! The situation will likely be worse in 1980. This expectation is based on the fact that adolescent suicide in Alberta has increased 1250 percent in the last thirty years, and the annual increase for those of age twenty and younger is about twenty percent per year.[5] Actually, the rate of suicide has been increasing for all age groups, but the greatest increase has occurred in those age twenty-five and younger.[6] Since the 1950's, the rate of adolescent suicide has quadrupled.[7] The rate is also increasing for young children.[8] There are children as young as five committing suicide in Ontario, Canada. Suicide is no longer rare in those younger than fifteen.[9]

Canada's male suicide rate is six times the rate of homicide.[10] For females, suicide is four times greater than homicide.[11] When one considers the money that is spent investigating, preventing, judiciating, and jailing crime, we can see that Alberta's 200,000 dollar annual campaign against suicide is definitely underfunded.[12]

Suicide is the most common cause of death in young negro women and American Indian youth.[13] It is the second leading cause of death in late adolescence and is surpassed only by accidents in this age group.[14] Being a student places one at special risk, for suicides of college students are fifty percent greater than suicides of those the same age who are not enrolled in such studies.[15]

Deaths from suicide increase with age. Those age 24 to 44 commit suicide most often, while adolescents make the most suicide attempts.[16] Studies which follow the patterns of cohorts (groups of people born in a five year period) carry frightening implications for the future. If the trend in a person's lifespan for suicide peaks at age forty, then this group of adolescent attempters will be contributing to astronomical suicide rates in the future![17] Also, it has been claimed that most adolescent suicide attempts are manipulative in nature, and not intended to produce death. They are essentially considered a cry for help. However, a recent study conducted at Toronto's Sick Children's Hospital, shows that this trend is changing. Five hundred and five adolescents were studied, and the majority were evaluated by psychiatrists as serious in intent. They were no longer making manipulative cries for help, but had serious wishes for death.[18] Thus, adolescent suicide acts may be growing more serious in intent.

The relationship between attempted and committed suicide is an interesting one. About 25 percent of those who make attempts go on to commit suicide at a later date, often using no more fatal methods than those used in previous attempts.[19] Four out of five suicides have made at least one prior attempt.[20] In those of college age, there are about fifty attempts for every completed act.[21] For younger adolescents, the ratio may be as high as 120:1![22] If we use the conservative number of 1000 adolescent suicide deaths per year, then the estimated Canadian rate of adolescent attempts is a shocking 120,000 per year.

Female adolescents tend to make more attempted than committed acts. Until 1965, young males committed suicide three times as often as females, despite the higher number of female attempts.[23] Seventy percent of completers are males, while seventy percent of attempters are females.[24] However, females have recently begun to narrow this gap and their rate of fatal suicide is growing faster than that of young males.[25] However, male deaths by suicide still outnumber those of females.[26] This difference in rates is likely due to cultural factors. For instance, in 1910 the suicide rate for females age fifteen to nineteen exceeded that of males, and male and female rates are equivalent in some Asian countries.[27] Sexual differences are also exhibited in choice of suicide method. Males use violent methods, such as firearms and hanging, while females prefer less lethal methods such as pills, gas, and wrist slashing.[28]

In general, adolescent attempts are not associated with sexual experience, drug abuse, alcohol abuse, bereavement, religion, socioeconomic status, duration of psychiatric illness, or a family history of suicide.[29] Adolescent committers show variance from this pattern since female adolescents who make serious attempts, have a higher proportion of mentally ill parents and alcoholic fathers.[30] Consequently, more family pathology is exhibited in the backgrounds of adolescent committers.

All suicide is greatly under-reported, but this tendency is particularly evident with adolescent suicide.[31] When suicide involves an adolescent, parents often deny the act and claim it was an accident - physicians, coroners, and police face parental pressure to falsify death certificates.[32] They tend to give these hostile and bereaved parents the "benefit of the doubt" wherever possible.[33] The cause of death is currently published in many countries. Cause of death should be made confidential to relieve the stigma on survivors. This would also decrease pressure on medical and legal authorities to under-report adolescent deaths from suicide.

Under-reporting of suicide also results from the fact that coroners consider their major job to be the ruling out of homicide. Consequently, they devote less effort and attention to suicide.[34] In general, programs for certifying, investigating, and reporting suicide need drastic improvement. The following procedures should be implemented to correct this situation.

(1) Standardize procedures for autopsies and toxicological tests.

(2) Courts and coroners should make use of a psychological autopsy team to investigate questionable deaths.

(3) Medical, legal, and police personnel involved in certifying, investigating, and reporting death, need more training in the area of suicide. Samuel Wallace found medical examiner's records to be blatently wrong in four out of twelve cases - this is not a very good record![35]

(4) The reliability and validity of current statistics should be checked. This could be done by running

independent studies of the incidence of suicide.

(5) Suicide should be made a "reportable" incident in the manner of certain communicable diseases.

(6) Hospitals should be more alert to possible suicide, and it should be mandatory to report suspicions in records. Currently, many hospitals don't even have coding systems which include suicide!

(7) Countries currently classify suicide deaths in many varying ways. There is great need for a standardized definition of what constitutes suicide. This definition of suicide should be routinely adopted by all countries. Also, means of handling suicide statistics should be made routine. Until this is done, differences in rates between countries, and even between different areas of the same country, could well be due to differential procedures of collecting, defining, determining, and recording suicidal deaths.

Until these procedures are implemented, the Suicide Prevention Center of Los Angeles will continue to estimate that at least fifty percent of adolescent suicide deaths are disguised as accidents.[36] Suicide deaths can be hidden in verdicts of accidental poisoning and car accidents.[37] In this regard, it is interesting to notice that the number of adolescent car accidents has steadily increased in recent years.[38] This increase is above and beyond the actual increase in the number of adolescent drivers.[39]

Some of this increase in auto accidents may be due to a greater tendency to consume alcohol when driving, but suicide contributes as well. Under-reporting of attempted suicide is even more prevalent because the adolescent attempts which come to the attention of hospitals or police are only the most serious acts. Private practitioners observe less serious suicidal behaviors - and they do not keep official records for public scrutiny and official tabulation.

In conclusion, statistics have provided interesting clues concerning suicide. However, statistics are of questionable value due to inaccuracies and under-reporting. Until these problems are corrected, statistics can only be used tentatively. This fact is not of great concern to those who have lost a spouse, friend or child through suicide. They will tell you that even one suicide is one too many. They know that suicide is the leading cause of stigmatizing and unnecessary death!

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CHAPTER 2

SUICIDE: DEFINING THE CONCEPT

Suicide is really a collection of different syndromes, rather than a discrete psychological entity.[1] A threatened or attempted suicide may be a vastly different phenomenon than a complete suicide. Adolescent suicide is also a different behavior than adult suicide. Unfortunately, these behaviors are incorrectly classified together under the label of "suicide", and this indiscriminant grouping masks important characteristics of various kinds of suicidal behavior. This chapter will define the concept of suicide more closely. The differences between threateners, gesturers, attempters, and completers of suicide will be explicated. Differences between the suicidal behavior of adolescents and that of adults will also be examined.

A number of authors have defined what is meant by the word suicide. Webster's dictionary says suicide is,

> the act or an instance of taking one's own life voluntarily and intentionally.[2]

This definition, like many others, has serious shortcomings. For instance, the phrase, "taking one's own life" excludes people who trick a friend into killing them or torment an animal until it attacks. The word "voluntarily" excludes practices of suttee and hara kiri which occur under pressure of custom or public opinion. Also, there are serious problems with the word "intentionally", for this ignores the fact that some suicidal behavior has ambiguous or unconscious motives. Finally, not all suicidal persons intend to kill themselves. They may simply wish to receive help or spare others harm.[3]

A better definition is that of Deshaies who defines suicide as

> an act of killing oneself, usually in a conscious manner, and taking death as a means or as an end.[4]

Here, Deshaies avoids the pitfalls of Webster's definition. He recognizes that suicidal behaviors are not always clear in intention, and do not always have death as their underlying goal. He also includes martyrdom and self-sacrifice which can occur under social pressure.

Erwin Stengel has a definition of suicide which includes attempted and completed acts. He states that,

> suicide means the fatal, and attempted suicide the non-fatal act of self injury, undertaken with conscious self-destructive intent, however vague and ambiguous.[5]

Like other short definitions, Stengel's has its problems. For instance, there may be no self-damage but the intent to die may have been there. Also, one cannot always infer intent from behavior, as in the case of the drowsy person who forgets that they already took their sleeping pills, or the person who has a careless accident. Finally, Stengel's definition does not go far enough. It does not distinguish those who make ambiguous attempts, those who really want to die, and those who are merely gesturing with no intent of death. Also, those who merely gesture or threaten are actually excluded by Stengel's definition.

Research shows that threateners, gesturers, attempters, and completers of suicide cannot be combined without masking important differences. For instance, attempters differ from completers in that they are usually younger, more often female, show fewer instances of classical mental illness, have fewer motives of ill health, are more often involved in unhappy love relationships, and tend to attempt suicidal acts which are more impulsive in nature.[6]

Despite these differences in motive, sex, age, and mental health status, there are unclear boundaries between various types of suicidal behavior. For instance, twelve percent of those persons making attempts will eventually commit suicide within two years of the first act.[7] Four out of five persons who commit suicide have made at least one previous attempt.[8] Therefore,we should conceptualize various suicidal behaviors along a continuum, with overlap between different categories (see figure 1). At one end are communication orientated behaviors, such as threats, while the other extreme would involve fatally intended acts. A person could progress along this continuum, beginning with mere threats. If threats are rejected, or ignored, then a gesture or attempt may be made. If the attempt is brushed aside, a fatal act may follow.[9]

If we realize the important differences between various types of suicidal behavior, we still haven't answered the question of how one distinguishes between a gesturer, attempter, or completer. Danger to life, or degree of injury are not reliable indicators of the intended seriousness of the action.[10] We cannot infer a person's intentions from the outcome of the act for many gestures are fatally miscalculated and many serious attempters are miraculously saved by modern medical technology (see figure 2).

As can be seen, the fact that a person lived or died tells us nothing about his real suicidal intentions, or which category of suicidal behavior he belongs in. It is difficult to define what is an attempt, an accident, and a seriously intended but bungled act. The best differentiater of various forms of suicidal behavior is the original intent of the act. The strength of this intent to die can be inferred by the lethality of the method used, or the possibility of intervention.[11] For example, committers often use highly lethal methods, such as a gun, and leave little possibility for others to intervene.[12] Gesturers or attempters prefer less lethal methods, such as pills, and allow opportunity for intervention.[13]

It comes as a surprise to many to learn that the intent of much suicidal behavior is not usually death.[14] Those wishing death are outnumbered by those who are ambiguous in intent, or definitely don't want to die. Suicidal behavior usually aims to communicate a cry for help in order to change an intolerable life situation. In fact, about seventy-five percent of suicidal persons give some kind of warning beforehand.[15] They are allowing someone a chance to intervene but are driven to the act when they find their appeals ignored, rejected, or treated as mere manipulative attention-getting.[16] The teenager who gives a friend his record collection, and states that he will not be needing it, is conveying a non-verbal plea which should be heeded. Had this adolescent really wanted to die he would not have dropped such hints.

Although suicidal behavior is not always death-intended, this does not mean it is an aberrant but silly business which is better off ignored. Many cries for help are tragically miscalculated and result in unintended death. Also, if the initial threats, gestures, or attempts go unheeded, the adolescent will lose all hope. He may see death as the only alternative. He could then commit a fatal act with death, rather than communication, as its real intent. If he could have communicated his problems and received aid, he need not have resorted to death as the only solution to his dilemma.

As we have seen, suicidal persons frequently have goals other than death. Edwin Shneidman has formed an exhaustive classification of various kinds of suicidal behavior. He uses the person's orientation towards death as the major differentiator between each form of suicidal behavior. He feels that suicidal behavior is intended, sub-intended, unintended, or contraintended in its orientation toward death. Each of these categories has several subcategories. An explication of Shneidman's classifications follows.[17]

ORIENTATIONS TOWARD DEATH

INTENDED. In all these examples, the person plays a direct and conscious role in his death. Many, but not all persons who die by suicide, are included in this category. There are a number of subcategories of this type of suicide.

(1) Death-seeker: This person has consciously verbalized to himself a strong wish to die. His method is calculated in his mind to bring certain death and he leaves little chance for rescue in the manner or site of his death. He is unambivalent in his intentions and acts accordingly.

(2) Death-initiator: Here the person believes he will die in the very near future, or is failing in some way. Not wishing to adapt to a lesser image of himself, or allow "it" to happen to him, he takes control. He will kill himself and die in his own way, in his own time, on his own terms. This is reminiscent of the person who quits before he can be fired. The achieving college student who

suspects he has failed his recent exams, may decide to kill himself rather than remain alive and adapt to a lesser image of himself. The elderly person dying of cancer may shoot himself rather than wait for inevitable death.

(3) Death-ignorer: This person does not realistically consider death, or chooses to ignore its implications. He believes his physical termination will not involve the cessation of his being. Examples include the husband who shoots himself because he wishes to rejoin a dead wife, or the child who wishes to be reunited with a deceased parent.

(4) Death-darer: In such cases, the subject truly wishes to die, but prefers to leave it to chance. He is a gambler of sorts who bets on the fact that his chances of living are few. He plays with fate and makes certain the deck is not stacked in his favor. Examples include playing Russian Roulette, flying a plane without knowing how, or driving with extreme recklessness. These are all gambles, but the chances of living are very small.

SUBINTENTIONED. Subintentioned orientations towards death involve cases where the person plays an indirect unconscious, or ambivalent role in their death. Death is hastened by carelessness, imprudence, or recklessness. Self-defeating behavior is prevalent. The four subgroups in the subintentioned category are as follows:

(1) Death-chancer: Like the death-darer, this person leaves death to chance. However, there is a much

greater chance of survival incorporated in the act because the person is more ambivalent in his intentions. Ambivalence prompts him to use methods of moderate lethality and leave more chance of rescue in the act. An example is the young girl who takes a moderate dose of barbituates and then waits in the living room, knowing her mother will likely be home from work in half an hour. In such cases, the risk is small, but death is still a realistic possibility.

(2) Death-hastener: This category includes persons who exacerbate a physiological problem that hastens a natural death. This can be done in two ways. First, the style in which a person lives can incorporate drug abuse, alcohol abuse, and malnutrition which can lead to death. Secondly, those who are ill can mismanage a treatment procedure in order to place themselves at risk. Examples include the diabetic teenager who goes off his diet or the young girl with kidney disease who often "forgets" her medication.

(3) Death-capitulator: A death capitulator is someone who fears death so much that fear plays a psychological role in bringing about his demise. He scares himself to death or gives in to it. Voodoo deaths are thought to work in this fashion.

(4) Death-experimenter: Here the object is suicide in small doses...death should be only partial or temporary. Often alcohol or barbituates are used to produce

a constantly benumbed state of mind and occasional unconsciousness. There is always a risk of such states lapsing into real death. When death occurs in these cases, it is often mislabelled as accidental.

UNINTENTIONED. This category involves cases where the person plays no role in his death. He has no conscious intention of hastening or effecting his death in any way.

(1) Death-acceptor: A death-acceptor is someone who does not wish death but is resigned to it when they know the end is near. Death is not wished but they are passively resigned to its inescapability.

(2) Death-welcomer: The death welcomer does not wish death as much as he wants an escape from pain, or unendurable illness. Rather than a passive resignation to death, there is an actual welcoming of the end. Frequently people report a yearning for death after a lengthy, hopeless, and painful illness.

(3) Death-postponer: Such persons understand that death will occur but hope it will be a long time off in the future. This is the attitude which most of us have towards death. We assume it won't happen for some time, and push the whole idea to the back of our minds.

(4) Death-disdainer: The disdainer adopts a supercilious orientation towards death. He feels somehow above death. It may be that most healthy adolescents in

our culture are death disdainers, and of course, they realistically should be - for awhile. Eventually, most of them will realize that life has finality.

(5) Death-fearer: This attitude to death is characterized by fear and an avoidance of the topic. This person is phobic about death, and if he was told he was dying he might deny the fact and forbid others to speak about it in his presence.

CONTRAINTENDED. One is reminded of the story of the little boy who cried wolf when examining this form of suicidal behavior. It is well worth remembering, as well, that the villagers got tired of answering the boy's false cries for help and refused him aid when a real wolf came, thinking he was fooling them again. They ignored him when he needed help. The cry of "wolf", or "suicide", does serve a valuable purpose for those who are not yet intending to act. The cry mobilizes others unless, like the villagers in the story, they regard the appeal as mere manipulation and ignore it. Contraintended forms of suicide behavior have a communication, rather than death intent. However, they can become death intended if unheeded. There are two forms of contraintended death orientation.

(1) Death-feigner: The death-feigner simulates a real suicide act. Examples include lightly slashing one's wrists, or the adolescent who tells her parents that she swallowed a whole bottle of pills when she really took

two pills. Feigned acts can still be dangerous for they can be miscalculated or misfire. One boy thought he would scare his parents by appearing to take a barbituate overdose. He had been drinking heavily that evening and the number of pills which he considered a "safe" quantity actually killed him. Another boy timed his overdose around his father's return from work. His father returned late and the boy nearly died from what was intended as a nonlethal gesture.

(2) Death-threatener: The death threatener is someone who does not intend to die but threatens to do so in order to achieve help from others. This is not manipulative behavior but a plea to change an intolerable life situation. When not answered, these cries become more shrill. The movement on the lethality scale is always from less lethal to more lethal acts. Today's death-threatener is tomorrow's death-seeker.

Shneidman's classification of suicidal behaviors is more exhaustive than the shorter definitions with which we began this chapter. He is more precise in his work than is possible in shorter definitions. Such detail and precision are necessary to explicate the complex and multidimensional group of behaviors that we call "suicide." Shneidman uses the concept of death orientation to classify various suicidal behaviors. In doing so he avoids the pitfalls of using differentiators such as amount of self-damage, actual death, observed actions, or active self-involvement in death. These are poor ways of deciding whether a suicidal act was a mere gesture, or serious in intent. Only the person's orientation toward death can accurately tell us what sort of suicidal behavior was intended. Accepting a two sentence definition means glossing over important differences.

This chapter began with the statement that there is more than one kind of suicidal behavior, and Shneidman's classifications certainly highlight this fact. It is interesting to examine what sorts of suicidal behaviors adolescents display, according to Shneidman's schema, and whether these differ from the suicidal behaviors typically displayed by adults. In other words, when we talk of adolescent and adult suicide, are we speaking of the same thing?

SUICIDAL BEHAVIOR OF ADOLESCENTS

Although adolescent and adult suicidal behaviors share much in common, they are not identical. In fact, adolescents often display marked differences in suicidal behavior when compared to suicidal adults.

To begin with, the goal of adolescent suicidal behavior is seldom death.[18] The same cannot be said of suicidal adults.[19] Rather than seeking death, the adolescent may wish to punish himself, change his environment, provoke guilt in others, or appeal for help.[20] Thus, the majority of adolescents would be found in Shneidman's subintended or contraintended categories. They more often tend to threaten, gesture, or be ambivalent in their suicidal behavior.

Adolescents also have a greater tendency to begin with suicidal behaviors of low lethality, and commit suicide only after previous pleas for help have been ignored.[21] The suicide of an adolescent is not the impulsive act we think it is for the majority give these frequent and repetitive warnings.[22]

Adolescent suicide is less likely to involve observable mental illness, or signs of classical depression.[23] Unhappy family and love relationships are more common.[24] Therefore, stormy interpersonal relationships are more usual warnings than the apathy and observable guilt of many suicidal adults.[25] Where adult symptoms are found, they are generally observed in older adolescents.[26]

Finally, adolescent acts are often less lethal and more passive.[27] This is particularly true of adolescent females.[28] Consequently, they are less likely to die.

In conclusion, Shneidman's classification schema marks a great improvement in defining and differentiating various suicidal behaviors. His work is important to the field of adolescent suicide for two reasons. First, we have long perceived that suicidal adolescents did not wish to die so we have dismissed their behavior as mere manipulation, and non-suicidal in nature. Shneidman has shown that this is not so. There are many kinds of suicidal behavior, and not all have death as their orientation. We realize that people choose to kill themselves for many important reasons, aside from a desire for death. Therefore, adolescent acts are worthy of the label "suicidal," and should be viewed with as much concern. Secondly, Shneidman draws our attention to the fact that the suicidal behavior of an adolescent may have a different meaning than that of an adult. Adolescent suicide is different from the adult variety and the adolescent may be trying to accomplish something different than the adult when he displays suicidal behavior. It behooves us to realize that suicidal behaviors have goals other than death, and to respond to what the adolescent is asking of us. If there is one thing to be learned from Shneidman's work, it is the fact that the suicidal behavior of adolescents is often an appeal to live - not die.

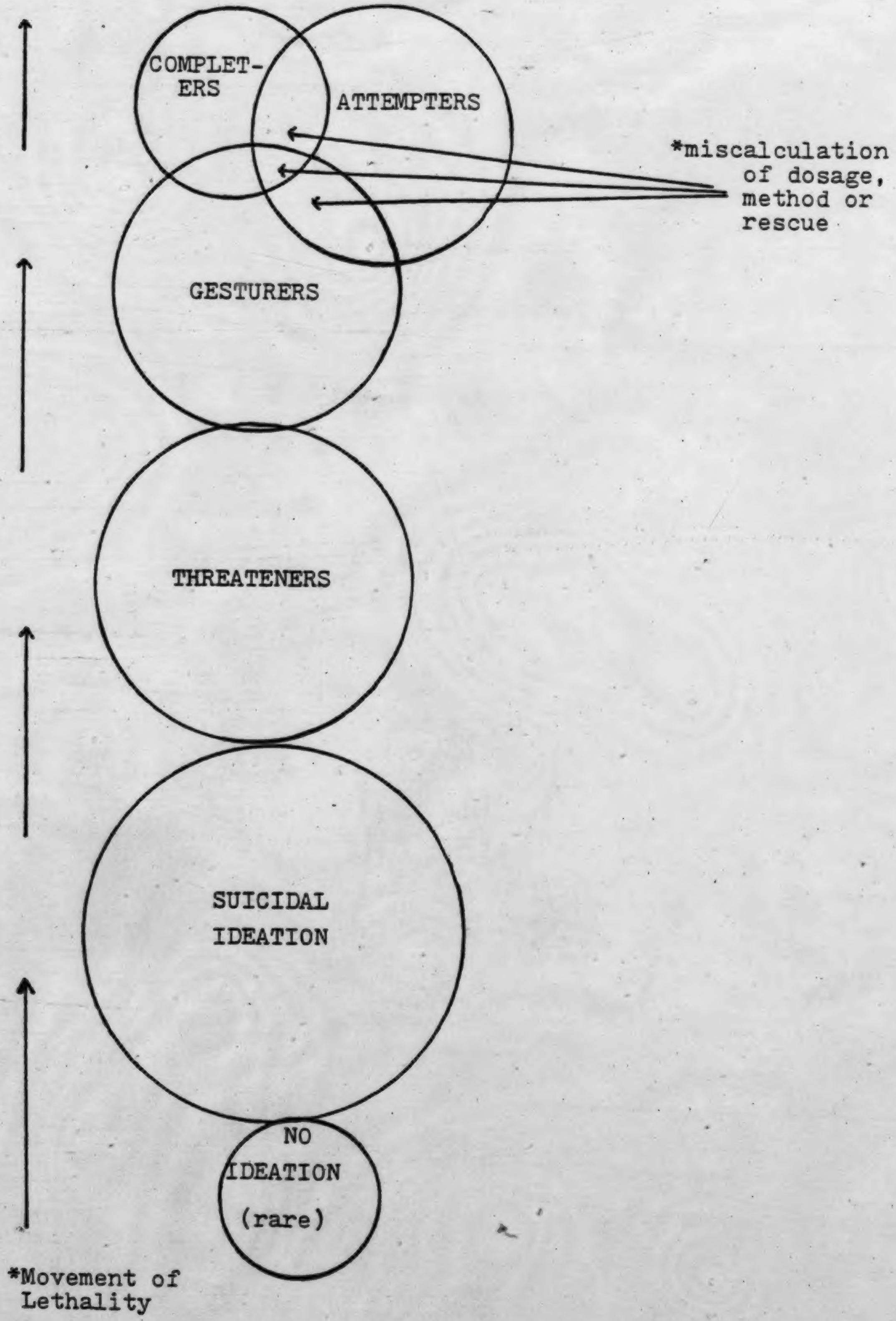
COMPLETERS
ATTEMPTERS
*miscalculation of dosage, method or rescue
GESTURERS
THREATENERS
SUICIDAL IDEATION
NO IDEATION (rare)
*Movement of Lethality

Figure One: The Continuum of Suicidal Behaviors

		INTENT	
		To Live	To Die
RESULT	Survival		
	Death		

Figure Two: Intent Versus Outcome

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PART TWO

EXPLANATIONS OF ADOLESCENT SUICIDE

CHAPTER 3

SOCIOLOGICAL THEORIES OF SUICIDE

Philosophers and writers have been fascinated by the topic of suicide for centuries. However, suicide did not receive scientific attention until the late nineteenth century when a sociologist, Emile Durkheim, completed the first study of the subject. Durkheim had been intrigued by the observation that suicide rates seemed to vary from one group of people to another, one country to another, and one time to another. What was responsible for these differences in rates? To this day, sociological research continues to turn up intriguing findings. For instance, suicide rates are higher among single and divorced persons, those professing no religious affiliation, and migrants.[1] High suicide rates are also reported when people are socially uprooted. An example of this is the growing suicide problem among Eskimo teenagers in Alaska.[2] Suicide rates are also generally higher among people who live alone.[3]

Durkheim created a sociological theory to explain such bewildering fluctuations in suicide rates. He felt that:

> The individual is dominated by a moral reality greater than himself; namely collective reality.[4]

Durkheim was not as interested in the individual as the societal forces which affect the individual. His emphasis was sociological rather than individual or psychological. He also dismissed all extrasocial causes such as climate.[5] In other words, he believed suicide was a rational and adaptive response to prevailing societal forces.[6]

Durkheim identified three types of suicide. Each type was linked to a particular form of social malaise. The first form of self-destruction postulated by Durkheim is egoistic suicide.[7] This results when the ego is left without its usual social supports. Thus, those living alone or isolated from group ties are thought to be at risk. Adolescents attending huge impersonal high schools, where they are separated from the community at large, experience this isolation from society. Being married or affiliated with a religious group are examples of cohesion that give protection against suicide. The second category considered by Durkheim is anomic suicide.[8] This form of suicide occurs when man's activities lack regulation. Lack of regulation is a product of rapid social change and uncertainty. When traditional values, structures, and routines fall apart, man has no societal guidelines by which to live. He is alienated from society and cast adrift on a sea of uncertainty. In times of rapid technological change, broken homes, and disintegration of the church, many adolescents feel anomie and a sense of future shock.

The third form of self-destruction, which Durkheim discussed, was altruistic suicide.[9] This category differs from both egoistic and anomic suicide. Contrary to a person being isolated, or finding no value consensus in society, altruistic suicide results when the person is too integrated in his social group. In other words, he is so closely identified with the group that he willingly sacrifices himself for the beliefs, or good, of the group. Examples include the Kamikaze pilot, the Indian custom of wife sacrifice after a husband's death, and the elderly Eskimo who wanders off to die when his tribe's supply of food is low. Altruistic suicide is probably the rarest form of suicide. It also seems to have the least relevance to the problem of adolescent suicide.

Durkheim's research prompted other sociologists to study suicide. Some examined cultural norms and attitudes towards suicide in an attempt to explain the phenomenon. Rates may differ between two countries for these reasons.[10] Examples include the higher rates of a country like Japan which does not condemn suicide, and even approves of it in certain social situations.[11] Another example would be the ostensibly different suicide rates of various religious groups such as protestants and catholics.[12] Rates are said to be lower in the catholic church due to its negative stance concerning suicide.

Other sociologists have examined achievement pressures and other social demands placed upon youth in an attempt to explain suicide in adolescence.[13] In particular, it is believed that the high rate of suicide amongst Japanese youth is due to that society's emphasis on achievement, competition and saving face. At the same time there are relatively few places in the Japanese school system for adolescents to meet these expectations.

It is also becoming difficult for adolescents to fulfill achievement and career needs at Canadian universities. Budget restrictions are forcing universities to increase tuitions and impose quotas. Thus, an honours grade average will no longer guarantee admittance to professional schools like medicine or engineering. This means that many bright students with strong achievement needs have to deal with feelings of failure when denied admission. It is interesting to speculate how many high school students are also feeling pressure to excel. Are they also feeling hopeless when they consider how the admittance grades to professional faculties have risen in the last fifteen years? It is a case of rising aspirations and expectations on one hand, and decreasing opportunities on the other. This is the most common student dilemma which counsellors in University Counselling Services must handle.

Whether sociologists are examining societal cohesion, cultural attitudes towards suicide, or societal aspirations and opportunities, they share the belief that suicide results from pervasive forces in society. Consequently, it may be assumed that only widesweeping changes in society will effectively lower the suicide rate. Sociologists suggest that psychotherapy is useful in individual cases but would not produce significant lowering of rates for large groups of people.

An Evaluation of the Sociological Approach to Suicide

Emile Durkheim and the sociologists who followed him, have contributed greatly to our understanding of suicide. Although they did not address themselves specifically to the problem of adolescent suicide, their theories have relevance when used to analyze the social pressures youth currently face. It is also worth remembering that the sociological approach was the first to objectively study suicide with the use of statistics. As such, it paved the way for a more scientific consideration of suicide.

Despite the fact that sociological theories of suicide broke new ground, they have serious limitations. The rest of this chapter will be devoted to a discussion of some of these problems.

The most obvious criticism concerns the fact that these theories were based, for the most part, on nineteenth century statistics of questionable validity. In some cases, the findings of that time have not been replicated in modern research.[14] Even statistics which have been recently gathered are of uncertain validity.[15] These statistics are not adequate enough to provide the sole support for a major theory of suicide.

A second caution that comes to mind concerns the fact that Durkheim based a major portion of his theory on ostensible differences in suicide rates. The differences seemed apparent, but we cannot be sure that they were real. There were no sophisticated statistical tools available at the time, so Durkheim could not have objectively tested the significance of such differences in rates.

Another characteristic of most sociological theories is the improper inferences they make from correlational studies. Sociological research tends to be correlational. This is acceptable, but these theorists have a tendency to believe that correlation means causation. They would be wise to remember that while two variables may be correlated, they do not necessarily have a causal relationship.

Sociological research also tends to be based on completed suicides rather than attempted acts. As was discussed in Chapter 2, attempters and completers may be two different groups of people. One cannot study completers and generalize such findings to attempters.

A further, somewhat mixed, criticism of sociological theories concerns their implications for treating suicide. Sociologists have performed a valuable service by suggesting that more significant progress with suicide is made when treatment programs involve pervasive community changes. However, there is no need to take the argument one step further by implying individual psychotherapy is not a valuable method of treating suicide. Surely the most effective treatment programs would involve community mobilization with individual therapy.

Finally, sociologists have concerned themselves with the study of groups of people. They are not as concerned with individuals. This makes it hard to understand why one person under certain social conditions chooses to die, while another in the same circumstances chooses to live. How can sociologists explain the fact that the majority of people desperately want life in even the most appalling social conditions? Erwin Stengel, a leading psychologist in the field of suicide stated:

> With very few exceptions, there is no situation causing individuals to commit suicide which would not be tolerated by most other people....[16]

Psychologists, such as Stengel, are vocal in their criticisms regarding sociologists' neglect of the inner individual. They offer the speculation that isolation is not caused by social factors, but results from inner disturbances of the individual. Such disturbances may cause the person to reject society. He may, in effect, be the own cause of his isolation.[17] In other words, perhaps Durkheim's observed states of social isolation are a result of, and not a cause of, personality factors.

Dissatisfaction with sociological explanations impelled psychologists to construct their own theories of suicide. Their thoughts on suicide are the subject of the next chapter. As the reader will see, early psychological explanations were diametrically opposed to the sociological position. However, psychologists are increasingly willing to incorporate elements of sociological thought into their theories of suicide.

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CHAPTER 4

PSYCHOLOGICAL EXPLANATIONS OF SUICIDE

The writings of Emile Durkheim inspired a more scientific approach to suicide. Early psychologists were quick to follow this inspiration, but they took a different direction from sociologists. For instance, Durkheim asked why the suicide rate varied from one population to another. Psychologists, on the other hand, preferred to examine those characteristics which differentiated suicidal from nonsuicidal persons.

Initially, psychologists were concerned with inner individual events, and disregarded sociological factors. However, there has been a recent trend amongst psychologists to incorporate sociological ideas in their theories of suicide. The result of such a mixture seems to be a fuller and better balanced explanation of suicide. Erik Erikson has produced a theory which includes some psychosocial concepts.

Obviously, there are differences among various psychological theories of suicide. This chapter will present the major approaches, beginning with the early psychoanalytic theories of Freud and Menninger. Neo-

Freudian explanations, such as Erik Erikson's, will also be covered.

Psychoanalytic theories of suicide have not gone unscathed. Many dislike the psychoanalytic assumption that suicide is the irritational product of ~~severe~~ mental illness. Existentialists, such as Rollo May, have been vocal in their criticism of the psychoanalytic approach. Existentialists offer a radically different view of suicide, and their ideas will be presented. The work of Jerry Jacobs will also be reviewed in the section concerning existentialism, as his research ties in well with the existentialist approach. Jacobs stresses the idea that adolescent suicide is an understandable means of attempting to cope with progressively deteriorating life situations. In other words, it may be the adolescent's last desperate solution following many unsuccessful attempts to cope with a crisis.

The chapter will conclude with a discussion of André Haim's developmental explanation of adolescent suicide. Haim explores the normal developmental characteristics of adolescence to explain why adolescents demonstrate suicidal behavior. While not intended as a complete theory of suicide, able to stand on its own, Haim's work is a useful supplement to other theories. His thoughts provide a valuable conclusion and added perspective to each of the previously examined interpretations of adolescent suicide.

The sensible place to begin a discussion of all these theorists is at the beginning...with Freud. Freud was the first psychologist to study suicide. He was followed by Karl Meninger and other psychoanalysts. Their contributions to the field will now be examined.

PSYCHOANALYTIC EXPLANATIONS OF SUICIDE

Freud postulated the existence of a death instinct to explain why man indulges in various forms of self-destructive behavior.[1] In a sense, all men are said to be vulnerable to suicide. It was the counterbalancing force of the life instinct which prevented most people from taking their own lives.[2] However, stress which a person could not handle, might cause that person to regress back to a primitive stage where the ego was not protected.[3] At this level there would be deficient reality testing and more impulsiveness.[4] In such a state, the ego might allow the death instinct to take over.[5]

The other central hypothesis in Freud's explanation of suicide was the concept of turning anger inward.[6] He believed that depression, and consequently suicide, occurred when anger was turned inward. People were thought to turn anger inward when they identified with a person they both loved and hated, such as a parent.[7] Because the superego is made up of such incorporated love objects, one could kill the parent by killing the self.[8] Implicit in this theory is the idea that suicidal people are depressed.

Of course, the suicidal child could simply vent his rage outward against the hated object. However, Freud felt it would be turned inward for two reasons. First, the rage the child feels towards the other may make him feel very guilty and worthless.[9] He must then kill the worthless self as well as the hated and introjected love object. Second, the child may be very dependent on the love object.[10] Therefore, he may believe he has to repress his rage and turn it inward. To direct the rage outwards would evoke anxiety about losing the love object he is so dependent upon. Research has indicated that many suicidal adolescents are involved in symbiotically dependent relationships.[11] In such circumstances, it is easy to understand why it would be impossible to express hostility. He dare not show rage for fear of disrupting the symbiotic relationship.

Attacks on the self and the introjected love object need not take the form of suicide. Freudians recognize that the death instinct may appear in other ways.[12] Antisocial acts, accidents, and drug abuse are a few examples of adolescent behavior which Freudians interpret as "death wishes."

Some psychoanalysts, since Freud, have felt that a symbolic attack on the incorporated love object may not be the only reason for a suicidal act. In some persons, suicide can be an attempt to recover or rejoin a lost love object.[13] This may explain suicidal acts of children who have not yet formed a mature concept of death. They see death as a magical and reversible event where they can once again be with the lost parent. Even adolescents may not fully grasp the finality of death.[14] They may feel satisfaction at the pain their death will cause a loved one, as if they would really be there to gloat after their demise!

Karl Menninger also examined motives underlying suicide. He believed there were three psychodynamic forces behind each suicidal act, and that all three motives were present in varying intensity in each act.[15] The first of these was the wish to kill, and was shown by conscious hate, blame, and driving others away.[16] The second impetus was the wish to be killed, and was inferred from self hate, guilt, self blame, and submission.[17] This motive closely resembles Freud's concept of anger turned back upon the self. The final motive was the wish to die. It was shown by hopelessness, discouragement, and despair.[18] In contrast to the active wish to be killed, this is a passive giving up of life. It corresponds to Freud's notion of a death instinct.

As can be seen, Menninger felt suicide involved a mixture of motives. Other psychoanalysts have offered a multitude of conditions which predispose the ego's splitting up. Some of the most common are:

(1) A disorganized or weak ego structure which breaks up under relatively low psychological stress.[19]

(2) Tendencies of a person's drives to be fixated at immature levels, resulting in masochistic or sadistic urges.[20] Examples would be the adolescent who hopes to hurt others by his death or the self-mutilating adolescent who expresses intense self-hatred. Here, there are urges to punish the self or others.

(3) Deformities of the superego.[21] Deformities might be due to cruel, rejecting, dead, absent, or uncaring parental figures.[22] Even the involuntary and accidental death of a parent may be seen as a personal rejection by a child.[23] The child may irrationally feel that if their parent had loved them they wouldn't have died and left them. Traumas of loss and rejection are felt to be most serious in early childhood.[24] These particular types of childhood trauma can have two results. First, the child may be unable to form close and satisfying interpersonal relationships in adolescence.[25] He may become isolated. Second, the child may develop a rigid perfectionistic superego which sets impossible demands for the self and others.[26] Such an adolescent cannot help but hate himself for he can never measure up to his impossibly high standards. His suicide may be an attempt to destroy the one flaw in a perfectionistic character, rather than destroying the self. He is also disappointed in others, since they cannot meet his unrealistic demands. He constantly feels disillusioned

by himself, others, and the state of the world. Psychoanalysts have cited numerous studies which they claim demonstrate the effects of early rejection trauma. In a survey of such research, Rushing found that 17 to 50 percent of committers had lost a parent through divorce, separation or desertion.[27] Fourty-two to 77 percent of attempters had lost parents in the same manner.[28] Parental loss through death was 45 percent for committers, and 24 to 30 percent for attempters.[29] The general population had only a 20 percent rate of parental death.[30] Psychoanalysts cite such studies to support the idea that suicidal people tend to experience a significantly higher rate of rejection or loss traumas. That such early parental loss results in depression has been reported.[31] Results of dependency and symbiosis have also been cited.[32]

(4) Strong libidinal attachments to a dead loved one.[33] Here, the adolescent may fantasize or have an unconscious urge to rejoin a dead loved one.[34] Such irrational urges may exist in adolescents and even adults, who would be expected to have a mature concept of death. An example is the elderly man who leaves a suicide note claiming that he wished to rejoin his dead wife.

(5) Rejection by, or loss of, a love object which has been loved in a symbiotic and dependent fashion.[35]

Here, the adolescent is so over-identified with the other that he cannot endure the end of the relationship. Even the mere threat of its demise, such as an argument, may spark severe anxiety. The adolescent is so involved with the other that he cannot conceive of life without that person. He hasn't a strong enough sense of self to feel capable of a separate life and identity.

(6) Recent psychoanalytic literature has begun to stress the adolescent's anxiety over role diffusion as a contribution to ego breakdown.[36] The idea of role diffusion may have great importance to the study of adolescent suicide. More will be said about it in the following discussion of neo-Freudian theorists.

The following section concerning neo-Freudian theorists, will be devoted to Erik Erikson's work. It is felt that his concepts are very pertinent to the topic of adolescent suicide.

THE NEO-FREUDIAN APPROACH

Erik Erikson felt that anxieties related to role diffusion and intimacy were more prevalent amongst adolescents than the psychosexual anxieties described by Freud.[37] Erikson postulated eight psychosocial stages spanning a person's entire lifetime.[38] Each stage has its own problems which a person must resolve. He will only mature and move to the next stage if he solves the challenges inherent in previous stages.[39] The major tasks facing the adolescent are finding an identity and establishing a sense of intimacy with others.[40] If he fails at this, he sinks into role diffusion. Symptoms of role diffusion include experimentation with negative identity, self-consciousness, fear of the future, and impatience while waiting for the future.[41]

Erikson feels that society invites the unfolding of each stage. In other words, society is usually constructed to provoke and aid the search for identity.[42] In order for youth to find an identity society must give them freedom and opportunity to test out ideas and options.[43] They also need social settings which encourage their relatedness to others. At present, society is providing fewer opportunities to aid youth in finding relatedness and identity. Perhaps our social structure even hinders this process and actually produces role diffusion and isolation in adolescents.

Implicit in Erikson's theory is the idea that psychological and social forces interact to produce adolescent suicide. Unlike Freud, Erikson does not concentrate solely on psychosexual forces. He also places less stress on early determinants of adolescent problems. For him, psychological problems arise during the whole lifespan. Therefore, one need not always look at the suicidal adolescent's distant past for clues to current problems. We should look at what is also happening to the adolescent in the present if we wish to help him. Erikson's emphasis on psychosocial factors, and his willingness to look at what is happening to the adolescent in the present, provide welcome amendments to traditional psychoanalytic approaches. Neo-psychoanalytic theory has increased our understanding of adolescent suicide. However, this discussion of psychoanalytic approaches would not be complete without the cautions which follow.

An Evaluation of Psychoanalytic Explanations of Adolescent Suicide

The methodology used to develop early psychoanalytic theory has serious limitations. Freud analyzed a highly nonrandom sample of people at one particular time in history. The majority of his patients were wealthy Viennese women caught in the grip of Victorian repression. Vienna itself was in great social turmoil at the time. It is doubtful if all of Freud's theory can then be generalized to people of modern times.

Many concepts included in Freud's theory are untestable. For instance, his vague notion of a death instinct defies translation into clear and observable terms. Such concepts are too elusive.

It is also worth examining how the tenets of psychoanalytic theory have stood up to modern research. The idea that suicidal people are depressed or psychotic has not always been supported. Many suicidal people are not observably depressed or mentally ill.[44] Psychoanalysts reply that suicide itself is proof of depression, but this is mere circular logic.

Another concept contradicted by research has been Freud's idea of aggression turned inwards in suicidal people. Studies show that some suicidal adolescents are aggressive, hostile, and delinquent.[45] They turn aggression outward. This data would require a revision of psychoanalytic theory to incorporate outward aggression in some cases of suicide.

The idea that a unique loss or rejection trauma in childhood causes suicide, is also not well supported. Research on broken homes, parental loss, and parental death, shows that both suicidal and nonsuicidal persons experience these events in early life.[46] It is only when the traumas keep reoccurring on into adolescence that suicidal urges result.[47] Thus, it appears misguided to focus on a unique traumatic event in the early life of an adolescent. It is more enlightening to look at the adolescent's whole life history. Therefore, we must examine not just the broken home, but what came before and after it. A father's death at age five means less than the mother's two unhappy marriages since, and the conflict with the current stepfather. Of course, neo-Freudians like Erikson realized this drawback and did emphasize the person's whole life history.

Early psychoanalytic views of suicide were based on patients who came to self-destruction through depression. It is this author's belief that there are at least two, and maybe more, types of suicidal adolescents. Perhaps psychoanalysts examined only one type of suicidal person when they reported findings of depression, broken homes, inward aggression, and symbiotic dependency.[48] It is possible that other research contradicts these psychoanalytic findings because it is examining a different, or nondepressed type of suicidal person. Psychoanalytic research findings may be true of depressed suicides, but not other types.

That this hypothesis may be valid is suggested by two research findings. First, studies show that suicidal adolescents who are depressed, more often come from broken homes than nondepressed suicidal adolescents.[49] The second provocative finding concerns a study in which one-half of the suicide attempts of people from a broken home followed disruption of a close interpersonal relationship.... Only one quarter of the subjects from intact homes attempted suicide in these circumstances.[50]

A final criticism of traditional psychoanalytic theory concerns its lack of attention to environmental factors. Such attention would be needed to explain why more men than women complete suicide and why there are fewer suicides in wartime.[51] Stretching traditional psychoanalytic concepts to explain these facts is possible, but a little extreme. Of course, neo-Freudians, like Erikson, have remained within the psychoanalytic approach while introducing a willingness to incorporate psychosocial concepts. As such, Erikson and other neo-Freudians, did much to eliminate the over-emphasis on inner psychosexual factors.

Neo-Freudian revisions of traditional psychoanalytic explanations were not enough for some theorists. Existentialist thinkers, such as Rollo May, proposed a way of viewing suicide which was radically opposed to all psychoanalytic traditions. Their views are presented as a provocative alternative to psychoanalytic theories of suicide.

THE EXISTENTIALIST VIEW OF SUICIDE

Existentialist concepts of suicide are diametrically opposed to psychoanalytic ones. To begin with, they are against trying to understand a psychological problem such as suicide by searching for distant causes in a person's childhood. As Rollo May says:

> But if, as I sit here, I am chiefly thinking of these whys and hows of the way the problem came about, I will have grasped everything except the most important thing of all, the existing person.[52]

Existentialists are also opposed to the psychoanalytic belief that suicidal people are severely mentally ill or irrational. They feel these people are unhappy but capable of choice and responsibility.[53] They are not the victims of unconscious forces and traumas. As such, existentialists do not search for hidden and unconscious motives of suicide.

When discussing suicide, both sociological and psychoanalytic theorists assume that pathology and forces beyond the individual's control are at work. On the other hand, existentialists feel man is rational and responsible for his choices, even when he is in crises. They go so far as to say that suicide is a choice which confronts every man, and it is a rational alternative for some mentally healthy individuals.[54] Rollo May explains:

> With the confronting of non-being, existence takes on a vitality and immediacy, and the individual experiences a heightened consciousness of himself, his world, and others around him.[55]

The contemplation of suicide may even be a healthy thing because man can choose to truly "become" only when he has considered the other alternative...not becoming.

As can be seen, existential views of suicide certainly contradict traditional approaches. The merits and drawbacks of these ideas will now be examined.

An Evaluation of the Existentialist Position on Suicide

The major criticms of existentialist ideas are two-fold. First, when applied to suicide, the approach is only a loose philosophy and not a detailed theory of suicide. Second, the theory does not detail explicit methods of treatment. Nevertheless, powerful philosophies, and general approaches to suicide treatment, lie implicit in the theory. We don't learn about methods but we do discover beneficial orientations concerning how one should approach "being with" the suicidal client.

A further asset of the approach is that it is highly nonjudgemental and places ultimate faith in the suicidal adolescent. There is also less emphasis on mental illness and sickness. The client is someone in crises, but he is told he is still a rational person capable of making choices. Consequently, the already embarrassed, guilty, and burdened client is left some dignity when he accepts the therapist's helping hand.

If the existentialist approach can do anything for the field of adolescent suicide, it should hopefully end the solicitous horror, and well-meaning repugnance, which suicidal adolescents encounter amongst those in the helping professions. As one young suicidal client put it, "Geez! They watched me like a hawk...as if I was crazy or something! Everyone was so worried about me, you know. It was kind of nice cuz I know they wanted to do something...but uh....it's embarrassing, you know. I wasn't going to do it again, but no one asked me! I didn't want to do it no more, and I know why I did it in the first place. I mean, the problem's getting better...my dad's been really good now about talking it over and he wasn't as mad as I thought he'd be when he found out about me being gay. You know, I could have told them why I did it but no one asked me. They just watched me and never asked me.... Geez I felt stupid!"

The basic tenets of existentialism have found practical expression in the work of Jerry Jacobs. Jacobs calls his approach a theoretical-methodological orientation.[56] He does not analyze childhood traumas but chooses to examine what is happening to the adolescent recently. He feels that the suicide attempts of adolescents are not irrational, impulsive, maladaptive, or unconscious in nature.[57]

Jacobs' central hypothesis is that:

> Adolescent suicide attempts result from the adolescent feeling that he has been subject to a progressive isolation from meaningful social relationships.[58]

He sees suicide as a progressive failure of adaptation, which leads to isolation and finally a loss of hope. It is a tragic but simple process which can be understood without talk of death instincts or mental illness. He is concerned with recent and observable events in the adolescent's life, rather than unconscious and inner psychological events. Jacobs describes the observable process leading to suicide as follows:[59]

(1) A long-standing history of problems which begins in early childhood and continues until the onset of adolescence.

(2) An escalation of these problems once adolescence begins. These problems are greater than those usually associated with adolescence.

(3) A progressive failure of available adaptive techniques

for coping with old problems, and the new escalating ones. This leads to the adolescent finding himself increasingly isolated from meaningful social relationships.

(4) This is followed by a disintegration of any meaningful social relationships in the days or weeks just prior to the attempt. It is at this time that the adolescent feels he has reached the end of all hope.

(5) This results in an internal process whereby the adolescent justifies the act of suicide to himself. He bridges the gap between thought and action through this justification process.

Jacobs feels that suicide is a rational and adaptive process.[60] It is an attempt to solve a problem when less drastic measures have failed. In a research study he completed, Jacobs found that suicide attempters were reluctant to resort to drastic measures until they had exhausted all other means of coping. They tended to use the problem solving techniques of "normal" adolescents and only when these were unsuccessful did they employ stronger measures like suicide.[61]

Jacobs' theoretical-methodological approach is an exciting and immensely useful view of suicide. Its applicability to the field of adolescent suicide will now be examined.

An Evaluation of Jacobs' Theory of Adolescent Suicide

To begin with, this theory is based on actual research. Jacobs confines himself to clear and observable concepts which make such research possible.

The theory has great use in treatment too, for the steps Jacobs describes are observable and involve recent events. Any therapist can see the process happening for there is no need to make inferences about death wishes, or whether the client's ego has been impaired by the death of a parent. This brings a sense of assurance for the therapist. He has something more to work with than ephemeral ego states, and the client's unconscious motives which he is supposed to uncover.

Jacobs' theory has great usefulness in the area of risk evaluation. We evaluate suicidal risk in the adolescent client simply by observing and discussing what actual events are happening in his recent life. Once we know this, it is a simple matter to pinpoint how far the client has progressed in Jacobs' five step process of suicide.

Jacobs' theoretical-methodological approach may also lead to more effective treatment of suicide. We are dealing with an observable and rational process. Therefore, we can more easily assist the client through his suicidal crises. Instead of delving into distant and unconscious traumas, we are encouraged to assist the adolescent with practical realities occurring in his life at the moment. As one client put it, "I don't want to know why I'm homosexual! I don't even know if it's possible to really know.... I mean no one knows for sure why people are gay. I'm just here (in counselling) to learn how to live with it so I don't have to try and kill myself again!"

Jacobs' work offers much to those concerned with the detection and treatment of suicide. It is hoped that his approach will spark new directions in the fields of suicide research, prediction, and treatment. It appears a truly effective means of meeting the growing problems of adolescent suicide.

There is yet one other major school of thought concerning the process of how adolescents come to be suicidal. This is the developmental approach found in the work of André Haim. Haim examines the normal characteristics of the adolescent life/stage for the contributing factors of adolescent suicide. Our discussion of suicide theories would be incomplete without this particular perspective.

A DEVELOPMENTAL THEORY OF ADOLESCENT SUICIDE

Haim feels that there are four adolescent characteristics which contribute to suicide. These factors are: a tendency to resort to action, manipulation of the idea of death, new cognitive capabilities, and a tendency to moodiness due to biological and environmental factors.[62]

Haim refers to these characteristics as contributory factors, rather than causes.[63] To cause suicide, a condition must be found in the majority of suicides. To put it another way, it must cause suicide in a majority of cases where it exists. Certainly, Haim's four developmental characteristics do not meet these criteria.[64] However, when combined with other significant stresses, these factors may contribute to suicide in adolescents.[65] In this regard, Haim believes there is no one cause of adolescent suicide.[66] A host of biological, psychological, and sociological factors are responsible.

With these introductory remarks in mind, a discussion of Haim's suicidogenic adolescent characteristics will be presented in the following four sections.

1. The Tendency of the Adolescent to Resort to Action

This may occur because of:

(a) The use of action as a defence, where anxiety is reduced and denied by acting-out behavior.[67]

(b) Adult attitudes which foster non-communication in adolescents so that the adolescent falls back on modes of response typically called 'adolescent'.[68] Some examples of such parental attitudes are: "children don't have serious problems," "children don't commit suicide," "he just wants attention and doesn't mean it," and "adolescents have little of importance to say."

Where threats, slammed doors, and arguments have failed, the adolescent may fall back upon suicidal action as a last plea for help.

(c) Rapid physical changes may lead the adolescent into a preference for using physical action in an attempt to get to know his body all over again.[69]

(d) Intense new instinctual drives are combined with a sudden surge of physical energy at this time. This may lead to impulsive action.[70] Also, the rapidity of physical, mental, and emotional changes do not give the adolescent time to learn to control these impulses in a sure fashion.[71]

(e) There is often a gap between the adolescent's intensity of emotion and intellectual experience on one hand, and his verbal ability on the other.[72] This forces the adolescent to find other ways of expressing himself.

(f) Because the adolescent has many exciting new capabilities, he is busy testing them out and exploring their limits.[73] He often does this with action.[74]

All these factors combine in adolescents to favor a tendency to act. However, does this automatically lead to suicide? After all, this tendency to act is displayed by most adolescents in a constructive fashion. Examples include creative projects, social protest, part-time jobs, and sports. As such, the tendency to act does not explain suicide. However, it produces impulsivity which leads to the hasty choice of any method that is close at hand.[75] Acts may be poorly planned and prepared as well.[76] As such, impulsivity can result in many adolescents surviving attempts while adult suicides are more lethal. Thus, the cause of suicide lies at a deeper level than the tendency to action.[77] However, this factor can explain the less lethal nature of the act. In conclusion, it can be regarded as contributory in nature.

2. The Idea of Death

Adolescence is a time when we form a mature and abstract concept of death. Childhood beliefs of death as reversible, temporary, or far removed from one personally, begin to change.[78] Adolescents manipulate the concept of death to reach this deeper understanding. The adolescent's new cognitive capabilities allow manipulation to occur as never before.[79]

The adolescent is hit by the true emotional import of death for the first time. Aside from not having the abstract thinking abilities at an earlier age, he was likely shielded from death by well meaning adults.[80] He may experience anxiety as he begins to sort out the fact from the fiction of what he has been told. Manipulation and intellectualization of death are useful defenses against this.[81]

Another defense that may be employed is the manipulation of voluntary death, for the adolescent usurps death's fright and power by being in control of death's 'when' and 'how' himself.[82] Also, death can be used to assert independence from others and gain a sense of power over them.[83] They can deprive significant others of their presence forever without their consent ... They can live or not live, depending on what they choose.

The above discussion does not explain why most teenagers deal with death in constructive fashion, while a few do not. The idea of death may be a factor in adolescent suicide but it is not a complete explanation. This had led to a consideration of depression in adolescence.

3. Depression in Adolescence

Classical depression and psychoses are found in only 15 to 30 percent of completed adolescent suicides.[84] This may be due to one's definition of depression ... Although adolescents seldom exhibit classical symptoms of depression, mild or masked depression could be involved in many more adolescent suicides.[85]

Adolescence is not an easy time in western culture. Haim feels that our culture is structured in a way that contributes to moodiness and melancholy in adolescence.[86] The adolescent undergoes many reorganizations and our social structure makes this more difficult than it need be.

A major task of adolescence is the establishment of an identity.[87] This is not easy to accomplish when the mind and body are undergoing vast change.[88] When the adolescent is between his old self and the new self he is becoming, he may be plagued by feelings of emptiness and failure to recognize himself.[89]

Adolescence is a time when one looks for worth and independence, in addition to identity.[90] Unfortunately, adolescents are forced to play a childlike role under the kindly intended manipulation of parents and school. The young adult may therefore feel incapable of self direction or worth. At the very least it indicates that others don't believe in him, even if he himself feels capable.

By the teen years, the superego is also well developed. This has important ramifications for depression. As the young adult battles with new impulses he may feel guilt.[91] Also, he has formed ideals for himself, his parents, and society to live up to, but now realizes that others are not the 'gods' he once thought they were.[92] The adolescent gets a taste of real life for the first time and may be sharply disillusioned by society's inequities and problems.

To combat this, the adolescent endows others with his ego ideal. Examples might include a teacher, a love object, or a friend.[93] He may also take up social causes. He is usually disappointed in these ideals as well. Finally, he may resolve the problem by renouncing the unrealistic aspects of his ego ideal.[94] But, the adolescent whose ego ideal is rigid or inflexible cannot do this. He is doomed to constant disappointment in self, in others, and even social structures in general. Depression will result. Haim says the possibility of depression is even greater when the adolescent has demonstrated moodiness, resentment, and dissatisfaction in childhood.[95]

In this writer's opinion, masked depression is an important variable in adolescent suicidal behavior. However, it must be reiterated that most adolescents do not exhibit classic signs of depression.[96]

A fourth factor in adolescent suicide may be the adolescent's new cognitive capabilities. These will be discussed in the following section.

4. New Cognitive Capabilities

At the beginning of adolescence, a person masters abstract thought and philosophy. He can perceive himself, his immediate life situation, and his future in new ways. He examines the world as never before. All in all, he may not like what he sees and understands for the first time.[97] For instance, he realizes his parents are not perfect and his ambitions are perhaps unrealistic.

The adolescent's cognitive abilities also allow him independence from the reality of adults. For a long time, he has had only partial contact with reality for he relied on the thoughts of adults. Now he begins to assert intellectual autonomy from those around him and this can bring him into conflict with the long accepted ideas of others. His burgeoning intellect will cause conflict with adults who wish to keep him dependent and refuse to acknowledge his intellectual independence. Anxiety, stress, and dependence-independence struggles are all exacerbated.

Finally, the adolescent is capable of perceiving the world in new ways. By trial and error, he must construct his own personal reality and morality. There is a struggle involved, and constant unfamiliarity of new perceptions. He is like the first man on the moon as he learns to rethink his world. Feelings of inadequacy, confusion, uncertainty, and anxiety can result.

Once again, the preceding may be factors in adolescent suicide, but they are incomplete. They do not explain why many adolescents analyze the same situations with the same skills, and discover excitement, joy, or at least hope. They also cannot explain why many adolescents easily assume intellectual independence, or find fascination in the new reality their intellect creates for them.

An Evaluation of Haim's Developmental Explanation of Adolescent Suicide

It would seem that the adolescent life stage does contain many unique stressors. Such factors have been overlooked in most discussions of adolescent suicide. Developmental factors do not completely explain adolescent suicidal behavior, but they supplement our understanding of the problem.

This brings us to the realization that purely psychological or sociological theories are not capable of explaining suicide because either the environment, or the inner person, are ignored at the expense of the other. It would seem that suicide is attempted when there is an unfortunate conjunction of psychological vulnerability or problems, preexisting stressful social conditions, and the normal but additional struggles and tendencies of adolescence. During a difficult adolescence, one may not be able to handle psychological and social problems because there is a tendency to action, moodiness, and manipulation of the idea of death. Haim's theory has given us a greater understanding of how the characteristics of the adolescent life stage interact with both sociological and psychological factors. We come away with broader, interactional, views of adolescent suicide.

5

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CHAPTER 5

AN INTERACTIONAL THEORY OF ADOLESCENT SUICIDE

As we have seen in the last two chapters, both sociological and psychological theories are too narrow in scope to explain a complex phenomenon such as suicide. Each theory contributes only a small piece to an intriguing puzzle. We reach a complete understanding of adolescent suicide only when all these pieces are put together.

Some of the factors which likely interact in adolescent suicide are:

(1) Constitutional givens and special vulnerability to stress.

(2) Psychological problems prior to, or during adolescence.

(3) The normal biological changes and stresses of adolescence, such as rapid body and hormonal changes.

(4) Unusual stresses prior to, and during, adolescence. Examples are the death of a parent or a disturbed home life.

(5) The "normal" adolescent character which includes action, moodiness, and anxiety about manipulating

the concept of death.

(6) Difficulty in forming an identity and finding intimacy.

(7) Sociocultural factors such as economic change, anomie, cultural attitudes towards suicide, isolation, and impersonality.

(8) Impaired communication patterns which leave the adolescent unable to communicate with others in any way but suicide. Suicidal communication will be discussed further in Chapter 7.

(9) Society's unwillingness to recognize and provide for the normal needs of adolescence. This factor will be discussed at length in the rest of this chapter.

John J. Mitchell has developed a theory of adolescent development which this writer feels is extremely useful in explaining adolescent problems, and adolescent suicide in particular. Mitchell links much adolescent psychopathology to society's ignorance and denial of adolescent needs. He feels that society does this because it has an inaccurate view of the adolescent life stage.[1]

Society has correctly perceived that younger adolescents need acceptance, belonging, love, esteem, membership, and popularity. We believe that older adolescents are the same as younger adolescents, and we treat them accordingly. Nothing could be more wrong. Mitchell says,

> Our fuzzy understanding of the adolescent is

> rooted in our mistaken assumption that he is merely an oversized child.[2]

In actual fact, the older adolescent has new and different needs of self-importance, significant contribution, introspection, identity, making a difference, future oriented values, primal assertion, and intimacy.[3] These will presently be explained.

Actually, Mitchell does not attack traditional views of adolescence as much as he pleads for a more complete understanding of adolescent development. He admits that traditional needs of esteem, companionship, and security are still very real during later adolescence, but are less important at this stage than these newer needs he has postulated.[4] These new needs must be included in any theories if we wish to understand suicide. Also, society must begin to pay attention to them if we wish to have psychologically healthy adolescents and lower the adolescent suicide rate.

At present, we are not making provisions for the needs of older adolescents. In fact our society actively strives to preserve the traits of early adolescence in the older adolescent. When the older adolescent acts strange, sick, suicidal, or typically "adolescent," it is because society is structured to ignore their needs; not because this is the adolescent's true nature.[5] In other words, the storm and stress of adolescence is not natural. It is an artifact of the adolescent's psychological nature being met by incompatible social factors. As Mitchell says,

> Many of the problems our society presently faces are nothing more than young people acting out the alternatives before them. The restless flee and try to build their own private microcosm...the acquiescent remain, blocking out of consciousness that element of their nature which causes them pain; the angry stay and fight back....[6]

Thus, adolescents whose psychological needs are denied may withdraw, take flight into unreality, or become aggressive and delinquent. Mitchell feels that such behaviors are usually a result of incompatible social environments rather than any moral weakness of youth.[7] Apathy is a major psychiatric disorder and youth have a doomsday mentality because of our inability to understand and satisfy their deepest needs.

There is a further result of society's misunderstanding of the adolescent life stage. This is the ignoring of adolescents who need help. In our society the well adjusted adolescent is one who merely stays out of trouble. We are therefore surprised when such a "good" adolescent steals a car, or suicides, because we have defined adolescent adjustment as merely keeping out of trouble.[8] To be a "good" adolescent, he must deny many natural urges, for society provides few socially sanctioned outlets for them. Therefore, these model adolescents may be in deep psychological trouble at a later date.[9] In contrast, healthy adolescents placed in environments antithetical to their needs, rebel and renounce the situation they find themselves in.[10] Therefore, while we continue to be alarmed about delinquent adolescents, it is time we extended our concern to the "good" adolescent, for it is here as well, that we may find potential suicide victims.

To sum up, we must begin to recognize and satisfy adolescent needs if we wish to prevent delinquency, suicide, or mental illness in youth. We must change traditional visions of adolescence. Mitchell says,

> This vision of adolescence is analogous to the old stereotype of the black plantation slave who wants only to be taken care of, please his master, smile admiringly at his superiors, and heed their every command.[11]

This vision results in our tendency to understand older adolescents in terms of the needs, habits, and behaviors of younger adolescents.

How is the older adolescent different from the younger adolescent? To answer this question, we must look at the new needs which arise in later adolescence, between the ages of sixteen and twenty-one. We must be aware of these needs if we wish to stop pathological adolescent behaviors such as suicide. These needs, postulated by Mitchell, are as follows:

Self Importance

Youth experience self importance best through important work.[12] Unlike the child, the adolescent does not feel important when he is merely told he is important.[13] The adolescent must prove importance to himself and he does so through actions and important work.[14]

To be important, one must be essential, do relevant things, and contribute to the significant events of one's peers and family.[15] In our society, this is seldom possible for adolescents. They are marginal members of society whose major job is to wait and study until the important roles of adulthood come along.

Adolescents require self importance for many reasons. First, self importance gives the adolescent confidence to explore the difficult options presented by the environment.[16] Second, self importance provides a reserve of psychological strength to sustain the adolescent through stress. Third, the important adolescent is flexible and feels less threatened by new people and experiences. Finally, he is self reliant and does not need to depend on the judgements and opinions of others. In short, this flexible, curious, and independent youth, who takes a problem-solving approach to life, is the opposite of our suicidal adolescent.

When youth are denied self importance, several contingencies arise. First, they begin to seek artificial means of gaining importance, such as theft and one-upmanship.[17] Suicide attempts are also a desperate way to bring importance to a diminished self. It is a way of saying, "I count!" Second, future time ceases to exist because the adolescent without importance does not believe in the self or others. He feels he cannot rely on the future so he lives for the present. When the present is full of stress, as it is for the suicidal adolescent, he sees no future to offer the hope of a way out. Thus, the present and its problems are overpowering. Mitchell concludes,

> When the adolescent is stripped of importance, when he is depersonalized, time shrinks to zero. The future disappears and the past darkens. What is left is the present.[18]

When this happens, hope cannot exist. Suicide seems a viable "way out" to the adolescent in this frame of mind.

The Need for Significant Contribution

Adolescents need to make important contributions to their family and their social environment.[19] Unfortunately, the significant work of families tends to be monopolized by parents. There are also few opportunities in society at large to make a contribution. Adolescents are supposed to sit in school, waiting, learning, and preparing. They are looked after but have little opportunity to help others!

Adolescents unable to make significant contributions reach two conclusions. They decide they are incapable and incompetent, or they realize they are negligible and accept the poor esteem that comes from either decision.[20]

The Need to Sample Identities

Like Erik Erikson, John Mitchell believes that forming an identity is a major developmental requirement of adolescence.[21] Mitchell points out that an identity is not merely found.[22] The adolescent actively creates his own identity through exploration of his environment and introspection. An identity is not something that can be given, acquired, or learned. It is created from experience.[23]

The adolescent must form an identity because he cannot make major decisions about his life until he knows who he is. However, our society makes the identity creation process difficult. Mitchell states that,

> isolation from work, segregation from the community, and alienation from the society are each facilitated by the school system.[24]

Schools are insular places. They isolate the adolescent from the community and the important events in their world. This isolation is compounded by age segregation of schools and society at large, and our confinement of the adolescent to the peer group. It is not hard to see that creating an identity is difficult in these circumstances. Experience is narrow or artificial, and exploration is confined. The adolescent does not live in the "real" world, therefore, does not know much about it. This life-context is a highly anxiety-arousing experience; for some adolescents, death is the solution.

The Need for Role Experimentation

Youth undertake many roles which they must learn to handle, including: gender, competency, social, and independence roles.[25] The adolescent must actively experiment with each of these various roles and test out aspects of his inner self.[26] Unfortunately, youth are segregated from society so they often find it difficult to know what being a woman, a worker, or an independent person is. For example, we tell adolescents to "grow up" while offering little opportunity to them to explore what "grown-up" is. It is no wonder that dependence-independence conflicts are common. As we mentioned in Chapter 4, dependence-independence conflicts are pronounced in suicidal adolescents. Our social structure,which allows for role learning but not role exploration, aggravates this tendency.

The Need to Make a Difference

Youth must feel that they make a difference. If they do not, a form of psychological deterioration occurs. After all, one cannot be valued or truly loved unless they make a difference.[27] Thus, adolescents wish to love, build, change, and generally effect others in a tangible or emotional sense. It is the only way to say, "I exist" or "I count."

Our society makes it difficult for adolescents to feel they have worth and do make a difference. Adolescents have few chances to participate in worthwhile work or meaningful activity.[28] They are forced into the youth culture, power politics, and short-term striving.[29] Finally, the school setting, where they spend a major portion of waking hours, emphasizes superficial rules of acceptance, ritual, and conformity. It is a time of waiting, learning, preparation, passivity, and impotence.

Mitchell states that adults can tell children that they are worthwhile, but the adolescent satisfies this need only through doing. He must do things which make a difference as well as merely receiving adult assurances that he is worthwhile.

How do adolescents cope with their socially structured worthlessness and impotence? Some become cynical and resigned.[30] Resignation is sometimes carried as far as nihilism, where the adolescent sees life as meaninglessness.[31] The consequences of resignation are apathy, obsession with the present, a compressed sense of the future, and resignation.[38] This sounds remarkably like the hopelessness that suicidal adolescents experience! While some adolescents lie down and surrender, others accept their fate less willingly. If they cannot make a difference through proper social channels, they find delinquent means to say, "See me, I matter!"[33] This behavior is "reasonable" when one considers that another alternative - psychological death - is even more destructive.

Mitchell concludes that, while not all youthful problems result from lack of worthwhile and important activity, such a situation aggravates all other adolescent stresses. The impotent, resigned youth, who does not make a difference, comes one step closer to suicide or psychopathology.

The Need for Primal Assertion

This is the need to assert the self, and it is fulfilled by an activity which aggrandizes the self.[34] Mitchell describes four traits that satisfy the need for primal assertion. First, the adolescent must love.[35] Second, he must receive acknowledgement from others.[36] Third, he must derive a sense of participation from actually doing things with others.[37] Finally, he must possess a sense of mastery.[38] These experiences occur when the adolescent is given actual opportunities to change or manipulate his environment.[39]

These four traits of primal assertion are hard for adolescents to achieve in our society. Even if they can find affection, acknowledgement, and participation, the major component, mastery, is hard to come by.[40] Adolescents have few competency models or opportunities to master real life skills. They spend little time with adults because they are segregated into peer groups. They have little chance to carry out plans because their major job is passive learning in a school setting. Also, adolescents have been denied productive work. Mitchell rejects this tendency to exclude youth from meaningful work because it is through work that adolescents can effect their environment and gain worth.[41] Mitchell claims that adolescents involved in worthwhile work show fewer incidences of pathological disturbances such as drug abuse or suicide.[42]

When mastery is denied,adolescents strive to fulfill primal assertion needs through a frantic search for less effective means such as affection, acknowledgement, and participation.[43] When this happens, they become dependent pawns of the peer group, willing to do anything in order to belong.

If these roundabout means of seeking primal assertion fail, the need does not disappear.[44] Youth will seek primal assertion in immature, perverted, and even destructive ways.[45] Examples include apathy and hostility. Mitchell points out that this hostility may be turned outward or back upon the self.[46] Thus delinquency and suicide may both derive from the thwarted impulse for primal assertion.

The Need for Introspection, Self Analysis and Future Pull

Youth must have solitude to spend on inward exploration. They need chances to sample, evaluate, and accept the hypotheses they formed about themselves during this time.[47]

Adolescents also need to assess the future and where they are going.[48] Adolescence is a difficult time of life in our society and the ability to tolerate it is determined by one's perception of the future.[49] Adolescents occupy a marginal status in society but tolerate this if they perceive the future as offering more. They will regard the waiting period as worthwhile, or at least bearable. The future is regarded as worthwhile if it offers the promise of self esteem, acceptance, productive work, self-assertion, and intimacy.[50]

Many youth do not see bright possibilities in the future. They see unemployment, inflation, divorce, anomie, and isolation in impersonal cities. Any present pain such an adolescent experiences is overpowering because there is little hope of things getting better. An adolescent without hope may consider death a logical alternative. "Vices of self-destruction proliferate when the future has been cancelled."[51]

While some adolescents turn to suicide, others abuse drugs or alcohol when the future has lost its pull. Others do not resort to such drastic solutions. They simply do not take the efforts and risks needed to grow optimally.[52] After all, why make an effort if the future is a fearful or worthless thing? They become troubled adults who have either not resolved the tasks of adolescence, or have wasted their potential. Society must offer youth better opportunities for the future if it wishes to prevent adolescent suicide.

Needs of Companionship

The needs of companionship are recognition, belonging, self-esteem, and affiliation.[53] The first of these, recognition, is satisfied when others notice or acknowledge the adolescent's importance.[54] If recognition is not given, the adolescent may seek it in negative ways rather than be ignored.[55] Delinquent behavior is one way of saying, "Notice me, I'm important."

The second companionship need, belonging, is based on recognition but is more complex. Feelings of belonging are confirmed when others indicate the adolescent's presence is important to the group, in addition to accepting and encouraging him.[56]

The third need, self esteem, is gratified when others show the adolescent that he is respected and admired. Others feel he is a terrific person so he feels esteem for himself.

The final companionship need is that of affiliation. It is more basic than other companionship needs, for it is satisfied merely by being with others. The age segregated peer group is the usual place to satisfy affiliation needs.

While adolescents are able to satisfy affiliation needs in the peer group, belonging, self esteem, and recognition are harder to fulfill in this setting. The peer group can be an intimidating and cruel place, where it is hard to find acknowledgement or acceptance. Thus, many adolescents satisfy companionship needs with trivial affiliation, and some do not even achieve this. They cannot relate to others in a meaningful manner and they are desperately alone.

Schools contribute to the relatedness crises of adolescence. Their vast size and depersonalized atmosphere cut the adolescent off from most forms of relatedness - except the peer group.[57] Youth are not meaningfully involved in their communities or the important groups concerned with the running of their schools.[58]

Adolescents seldom experience genuine recognition, belonging, or esteem. Their lives lack involvement which, in turn, makes them more susceptible to suicidal impulses.

The Need for Intimacy

Some of the needs that Mitchell postulates are of the person-environment variety. Others, like the needs of companionship or intimacy, are of the person-person variety.[59] As such, the need of intimacy is not unidirectional in nature. It is reciprocal for it requires a deep involvement with another who is, in turn, involved with oneself.[60] Intimacy with another person is important because the conflicts of adolescence demand someone close with whom to share emotions and experiences.[61] A companion is necessary and an intimate friendship is important.

Many things impede intimacy during adolescence. The adolescent who fears rejection, or has a vague sense of identity, opposes intimacy because he risks being spurned, or losing his tenuous sense of self in another.[62] Thus, withdrawal and isolation are ways of coping with fears related to intimacy. As such, the adolescent who is alone may not have been rejected...he may have done the rejecting as a means of coping! He is not so much pushed away from others as he is pulling away. Are suicidal adolescents rejected and denied intimacy by others, or do they fear intimacy and push others away, thereby becoming suicidal? As we shall see in Chapter 7, both situations are possibilities. Suicidal adolescents do have trouble with needs of intimacy.

Dehumanization and depersonalization oppose intimacy because they deny the adolescent's inner feelings. When we relate to adolescents in a traditional, stereotypic fashion, we deny intimacy.

In addition to fear of rejection, vague self-identity, depersonalization, and insecurity can prevent intimacy.[63] The insecure adolescent cannot take the risks that intimacy demands. Nor does he feel he has the right to request intimacy from others.

Whatever the reasons for the adolescent not establishing intimate relationships, the consequences are serious. Loneliness, emptiness, aggression, social destructiveness, and self-abuse flourish where intimacy does not exist. The adolescent who cannot connect with at least one other person is set adrift and, clinically speaking, moves closer to suicide. As we saw in Chapter 2, a suicide attempt is often a misguided means of reaching out to others.

The Need to Experience Meaning

Adolescents need values, belief, involvement, and meaning.[64] They need to believe in the self, the future, and society.[65] Mitchell states that personality deterioration results when adolescents are deprived of meaning and legitimate values.[66] Traditional theories of adolescent development and suicide, often overlook these necessities.[67]

According to Mitchell, the need to experience meaning is satisfied in five ways.[68] First, the fulfillment of the previously mentioned psychological needs may give the adolescent a sense of meaning. Second, being involved in important activities contributes to meaning. Third, giving and receiving love are effective ways to experience meaning. Fourth, engaging in activities which contribute to social good enhances the sense of meaning. Finally, activities which allow one to express personal beliefs and values can produce a sense of meaning. In short, youth acquire meaning by experiencing beliefs and directly doing deeds. Meaning cannot be passively given or taught by parents and schools. For adolescents, meaning is a product of activity-not belief.

Mitchell feels that meaning crises flow from three sources: the normal developmental characteristics of adolescence, limitations of personal development, and the failure of the environment to offer meaningful involvement to adolescents.[69] Let us now consider the first of these factors. Normal characteristics of adolescence do lead to meaning crises. To begin with, the adolescent's intellectual development races ahead of his emotional development, leaving a gap which causes anxiety.[70] Intellectual development allows the adolescent to achieve greater insights into life and he begins to doubt the easy answers of childhood.[71] Disillusionment follows, and while he understands these disappointing truths, he has no experience in coping with them. Thus, meaning crises are a natural part of adolescent development. However, Mitchell points out that meaning crises become serious when compounded by an environment which stifles meaning.[72]

Our society offers adolescents little to believe in other than the pursuit of material goods.[73] Also, society allows adolescents little to do that is meaningful. Adolescents do nothing immediately important or vital for society. They spend their time in trivial and game-like pastimes within their peer group. Ask an adolescent where he is going for an evening and he will say he is going to "hang out" somewhere. This is not the material of which a meaningful life is made and adolescents know it!

Other environmental factors contribute to feelings of meaninglessness in youth. Being dependent on the opinions of others, rather than self-validating, is one example. Of course, adolescents are constantly dependent on the opinions and validation of parents and school. Being taught to be other-directed is another factor, and this is a "given" in the adolescent years. Having parents who are highly dependent on others for social approval and recognition, or parents who are motivated by materialistic and economic gain, can contribute to meaninglessness. Such parents emphasize achievements rather than inner pride. The result of these factors is an adolescent who is dependent on others for validation, approval, and survival, but is unable to relate meaningfully to others. Unfortunately, these factors are common during adolescence and so, therefore, is meaninglessness. As we will see in Chapter 6, suicidal adolescents are particularly dependent on others. We might speculate that they are acutely prone toward meaning crises, and their need for meaning is desperately undernourished. In fact, this idea is more than speculation. Irwin Ringel reports that the suicidal adolescents he studied were characterized by value disturbances.[74] They held subjective values which were changeable and nebulous. They had no firm or lasting values to give them a sense of continuity.

Suicide is not the only result of unsatisfied needs for meaning. Psychological disorders of all kinds result.[75] Mitchell says psychological health is strongly correlated with stable personal values.[76] Also, feelings of apathy, emptiness of the future, and withdrawal result from meaninglessness.[77] Rather than endure this, some adolescents adopt norms opposing society. They create what Erikson calls "negative identity." A final solution that some adolescents reach is pathological nihilism. They view the world as meaningless or absurd.[78] This produces feelings of boredom and depression.[79] Nihilism causes a loss of striving and an inability to form relationships with others. At its least, it is a passive giving up.[80] At its worst, it may result in suicide.[81] When nihilism becomes pathological, and not just a philosophy, life is excruciatingly painful. It is easy for an adolescent experiencing nihilism to say, "Why not kill myself? My life means nothing, my future means nothing, my death means nothing."

Meaninglessness can be countered by providing adolescents with a more meaningful environment than they currently experience. Such an environment can only occur when adolescents are given opportunities for productive activity and meaningful personal relationships.

CONCLUSION

We have devoted serious discussion to Mitchell's theory of adolescent development and psychopathology because of its important ramifications for the study of adolescent suicide. Since Freud, psychological theorists have believed that we can produce healthy and nonsuicidal adolescents by providing trauma-free childhoods, stable homes, and efficiently run schools with well trained teachers. In short, we provide a well controlled atmosphere where children can be effectively "socialized." We aim to educate and love the adolescent as much as possible while keeping him free of all the responsibilities of "real" life. These theorists have implied that, if we can solve broken homes, school and learning problems, family problems, etc., we can understand and prevent adolescent suicide. We will have ended all unfavorable influences which impede socialization and adjustment. Mitchell has highlighted the possibility that while these theories are insightful, they overlook significant facets of adolescent existence...especially the adolescent needs of primal assertion, significant contribution, making a difference, meaning, etc. Sheltering, affection, coddling, and protection (i.e., adjustment and socialization opportunities) will not assure healthy psychological development in adolescents. Nor will they prevent suicide! Suicidal adolescents do need stable homes, good schools, love, and good parenting...but this is only a baseline, and they need much more than this if we wish to understand or prevent suicide! We cannot continue to define adjustment, rather than accomplishment, as psychological health. We cannot insure suicide-free adolescents merely by improving family and school techniques aimed at producing mere adjustment. Adolescent suicide is due, in part, from not being involved in the responsibilities of society at large...of being excluded from higher values, contribution and true intimacy. In emphasizing these points, Mitchell states:

> Adolescent delinquency, suicide, psychoses, and neurosis are constantly "caused", so the experts tell us, by the weakness within particular institutions, that is, the family, the school, the penal system. If these weaknesses are corrected, problems will decrease, we are told. The larger appraisal is avoided. Adolescents don't take dope, steal cars, become ill, or commit suicide because minor needs such as popularity and acceptance are thwarted. They succumb to pathology because their entire life style is a charade - a fake existence where little of importance is allowed to take place. They cannot work or produce and thus are excluded from participating in the most highly prized activities of our

> society. They have nothing of substance to relate to because they are expected to sublimate their needs for relatedness into superficial peer gatherings and trivial social events: They have nothing to strongly believe in because they do practically nothing of importance .... Such conditions do not traumatize children, in fact, they cater to their childish nature .... For the late adolescent, however, and for the young adult as well, such conditions contradict the full force of their need structure and thus result in psychological disturbance.[82]

We must realize that our misunderstanding of adolescent development and adolescent needs has locked youth out of significant contribution and productive activities, while isolating and depersonalizing them at the same time.[83] If we wish to understand adolescent development, and adolescent suicide, we must realize that adolescents have different needs than children. We must then begin to provide for these needs. As Mitchell says,

> ...people whose psychological needs are unmet tend to perceive the world as unfriendly, bleak, and unworthy of their investment....[84]

Thus, we are creating suicidogenic environments when we deprive youth of important responsibilities, contribution to their community, and involvement in the "real" world. Our misguided "kindness" does the adolescent more harm than good. He isn't the only one short changed by this estrangement from society. We allow a vast amount of adolescent energy, talent and intelligence to go to waste at a time when we dearly need them. Social service programs are being cut back and we also need manpower for conservation efforts. Adolescents can fill these gaps through school-based work experience programs. They, in return, can derive the sense of worth which comes from contributing valuable services to daycare, hospitals, senior citizens, and conservation. Mitchell concludes,

> ...our society masochistically wastes youthful potential by outlawing its positive application and by keeping youth confined to schools... youth denied meaningful or productive activity become bored, resentful, and sick.[85]

While societal and school factors are not solely responsible for adolescent stresses, estrangement from society magnifies all adolescent predicaments. It is difficult enough to adjust to body growth, sexual maturity, changes in hormonal secretions, and the demand to make decisions on moral issues, without the extra pain that comes from society's denial of one's basic needs.[86]

Mitchell's viewpoints are provocative and a welcome ammendment to traditional theories of adolescent maladjustment and suicide. He highlights the role of the school in contributing to adolescent problems. Though the school is only one source which contributes to adolescent suicide, Mitchell's stance brings to mind Mark Twain's characterization of schools as "the organized fight of the grown-up against youth!" The next chapter, concerning research on personality variables associated with suicide, provides some indirect support of Mitchell's theory. As we have seen, Mitchell claims that adolescents react to the denial of their needs in one of two ways: one group becomes bored, apathetic, withdrawn, sick, and feels hopelessness, while the other is frustrated, resentful, seeks negative identity, and is acting-out or delinquent. These adolescents may also be immature and other-directed. Whichever route the adolescent takes, they both lead to self-abusive, self-destructive, or suicidal behavior. This writer feels that the next chapter confirms these different patterns of behavior. We shall also see that each of these two different reactions may be associated with different forms of suicidal behavior.

NOTES

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62. Ibid., p. 75.

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CHAPTER 6

PERSONALITY FACTORS ASSOCIATED WITH ADOLESCENT SUICIDE

The search for personality variables associated with adolescent suicide has been disappointing. Research literature on the subject is confusing and contradictory. Several things contribute to this state of affairs, the greatest being the failure of researchers to control for levels of suicidal intent. There are different levels of suicidal intent and each may be associated with different personality variables. Failure to define the intent of suicidal samples used may, therefore, obscure results. A second source of contradiction is the use of hospitalized suicide samples. These include suicidal adolescents in psychiatric hospitals. We cannot assume that the personality variables associated with this population apply to the vast majority of suicidal adolescents in our schools. Many suicidal students never come to the attention of doctors and psychiatrists - their attempts are not lethal enough to warrant hospitalization, and they do not exhibit signs of psychoses which would cause them to be admitted to psychiatric facilities. As such, they may have different personality characteristics. Finally, the factor of sex is often not controlled. Considering males and females, without differentiating between them, masks important psychological variables related to sex.

With these preceding cautions, the contradictory findings concerning personality variables will now be discussed. A large number of personality traits have been investigated. Upon closer inspection, there are few personality variables that apply to suicidal adolescents as a whole. However, clues appear if we ask what personality factors are associated with subpopulations of suicidal adolescents, such as gesturers, attempters, and completers. With this hypothesis in mind, let us now discuss some of these variables.

Hostility

One of the personality factors that has attracted considerable research is that of hostility and aggression. The literature is divided in its findings. While experts agree that suicidal adolescents are hostile, there is disagreement concerning the direction hostility takes. Some claim that suicidal adolescents are intropunitive.[1] Others feel they direct hostility outwards, producing an extrapunitive person.[2] Actually, this may not be a case of one finding being right and the other wrong. For instance, one study found intropunitive and extrapunitive characteristics in the same sample.[3] The majority of adolescents were found to act-out hostility, have only sporadic control from indifferent families, and be in trouble with the law. However, the other subgroup was intropunitive, incapable of rebellion and subject to the pervasive control of families with excessive expectations.

What produces these different findings? Sex of the suicidal adolescent is one factor. For instance, males may find it more acceptable to act-out aggressive suicide impulses and make more fatal attempts for this reason. Also, males may not make suicide attempts for the same reasons that females do. In other words, the non-aggressive female stereotype forces females to resort to suicide merely as a solution to frustration. Males do not need to use suicide for this purpose because society allows them to be aggressive. In consequence, suicidal behavior in males may result from intropunitiveness and self-blame, while females and adolescents often use suicide to act-out frustration and hostility.[4]

Another factor which may account for opposite directions of hostility is that of suicide intent. Those classified as serious in suicide intent tend to be intropunitive, while those of low intent seem to be extrapunitive.[5]

Dependence

One variable the research literature is in relative agreement on is that of dependency. Suicidal adolescents are often dependent, and this dependency is usually active and possessive, rather than passive.[6] In active dependency the adolescent sets out to manipulate another, as opposed to passive dependency where he merely accepts help. Suicidal adolescents also feel more ambivalent toward those they are dependent upon. It is seldom a happy or conflict-free dependency for the adolescent is in desperate clinging need of those he hates most. Therefore, he cannot show this hatred. Thus, he turns it on himself as a means of expressing the anger he feels toward the parent. Once dating begins, the symbiotic relationship may transfer to a love object.[7] Dating relationships are described as possessive. The following words from a suicidal adolescent portray this destructive interdependence vividly.

> Moreover it was after an afternoon in the country, which I hate for the same reasons as I hate the afternoons. The reason is simple: when I'm alone I stop believing I exist.[8]

Anxiety

Results of the 16 PF and Neuroticism Scale questionnaires show high anxiety among suicide attempters.[9] This anxiety is a long-enduring trait rather than a temporary or situational phenomenon.[10] These adolescents appear unconfident and are unwilling to venture. Worry and stress have been evident since childhood.

Social Isolation and Antisociality

There are two major patterns of social interaction displayed by suicidal adolescents.[11] Some appear to be cut off from human contact and are highly withdrawn. Other suicidal adolescents are characterized as aggressive, impetuous, resentful of criticism, and in disciplinary trouble at school. The former group is asocial, while the latter group is antisocial. Adolescents displaying high suicide intent often fit the asocial or withdrawn pattern. Those less serious in their suicide attempts tend to be antisocial.[12] There is a reason for this. Adolescents making less lethal attempts are probably appealing to others to change an untenable life situation. They ask for help in antisocial ways. Those of serious intent have stopped reaching out to others. They feel resigned and have withdrawn from human contact. They only want death and escape.

When comparing suicidal adults to adolescents, the adolescents tend to be antisocial. They sometimes display delinquent and sociopathic behavior while suicidal adults more often show withdrawal and depression.[13] In conclusion, both suicidal adults and adolescents demonstrate poor social interrelatedness. However, adolescents often display this through stormy and acting-out types of behavior. The poor interrelatedness of adult suicides tends to take the form of withdrawal. As such, adolescent suicide acts may be more directed at others. The adults have lost contact with "others" so the purpose of their suicide behavior is often death. They have lost the hope of ever reaching out to others.

Impulsiveness

Impulsivity has been cited as a characteristic of suicidal adolescents.[14] There is impoverishment of internal judgement, a low tolerance for frustration, and a tendency to be controlled by the whims of external stimuli.[15] There is a reduced ability to use internal cognition.[16] In other words, there is less tendency to think through behaviors and their implications. Thus, the adolescent may express frustrations through direct actions like suicide. However, those who are serious in their suicide attempt may be less impulsive and immature than those making gestural sorts of attempts. It takes forethought to plan and organize an act that will be highly lethal and kept secret from the interference of rescuers.

Self Concept

Research literature seems to agree that suicidal adolescents have low self-esteem. Poor self-concepts, excessive self-criticism, and guilt are common.[17] Suicidal adolescents may feel unable to cope with the world.[18] They believe this results from their own personal inadequacy, rather than feeling that the world is at fault for being too overwhelming.

As we saw previously, the suicidal adolescent has little independence from family or love objects. This is a source of low self-esteem because the adolescent does little for himself. Therefore, he develops little sense of inner safety, inner self, or control over himself and the world. There is also a further source of low self-esteem. As we will see in Chapter 7, families of suicidal adolescents may be critical and exert tremendous pressures for achievement. The adolescent is dependent on these persons but is unable to cope or satisfy their demands. It is easy to see how suicide can result from these conflicting forces!

Approach to Problem Solving

Little research has been done concerning the cognitive problem-solving techniques of suicidal adolescents. Most of the work on cognition has involved suicidal adults, and we have seen that there are differences between suicidal adolescents and adults. Nevertheless, these findings will be reported as hypotheses which tentatively apply to suicidal adolescents.

In general, research has found that both attempters and committers of suicide share common thinking abnormalities.[19] These abnormalities are not just present during times of suicidal stress.[20] They exist long before depression or suicidal feelings occur. Thus, these peculiarities are enduring ways of thinking.

Suicidal persons tend to have rigid and inflexible thought patterns.[21] There is dogmatism in their thinking and an inability to consider alternatives.[22] Consequently, they can be moralistic and critical of themselves and others.[23] A person like this is doomed to a negative view of life. The world cannot help but disappoint them when nothing lives up to their impossibly high standards. Disillusionment with life is a consequence of such thinking patterns.

Suicidal persons are also more likely to think in the present.[24] They lack the ability to project themselves into the future and are thus fixated in the present. Thus, present difficulties seem more overwhelming because there is no future to offer hope. An adolescent can tolerate immediate frustration only if he realizes there is a future with the end of the problem in sight. With the future gone, hope cannot exist. Suicide, or other desperate acts, may then seem the only way out of present troubles.

In summary, the suicidal adolescent seems highly dogmatic, and is easily disappointed in life. His immediate disillusionments appear more dreadful because he is orientated in the present. He is rigid, inflexible, and cannot perceive alternative solutions to his problem. Thus, he gets "boxed in" very rapidly. He feels excessively negative, can't come up with a solution, and has no hope. He sees death as the only way out.

Intelligence

Little is known about the intelligence of suicidal persons. Some research exists, but it is inconclusive and contradictory. Nevertheless, some tentative hypotheses will be presented, although these hypotheses await further research validation.

David Shaffer found that a sample of 12 to 14 year olds who committed suicide were physically precocious and intellectually superior.[25] However, this result could occur because a child this young would need "extra" intelligence in order to carry out the planning, secrecy, and skill of a successful suicide.

Most suicidal college students have above average grades.[26] These grades tend to fall in the semester preceding the attempt, but they do indicate superior ability.[27]

H.C. White found that a group of suicidal 15 to 19 year olds showed a bimodal score distribution on the Ravens Progressive Matrices Test.[28] Scores were either very high or very low. Also, vocabulary levels of serious suicides are reported as above average, while those of less serious attempters are said to be below average.[29] Finally, those who commit suicide may have better grades than less suicidal students.[30] These findings suggest the hypotheses that intelligence varies with level of suicidal intent. Thus, adolescents with serious intent may demonstrate superior intelligence, while less serious suicides may have average to below-average intelligence. However, this hypothesis awaits research validation.

Regardless of ability, suicidal high school students often have poor academic records.[31] Their grades do not reflect the average or superior ability that many of them have. If they have been achieving, their grades usually drop prior to the attempt. Also, as many as a third have left school for nonacademic reasons.[32]

Value Orientation

Suicidal adolescents often hold subjective values.[33] Subjective values are based on the premise that, "What is right is what is useful to me." There are no firmly rooted beliefs concerning life so the adolescent has no "inner core." His values change with the drift of the wind. This is a bewildering and anxious experience. The adolescent does not know who he is or what he stands for. He may therefore fall prey to antisocial behavior, nihilism, a diminished sense of self worth, and suicide.[34]

Mental Health

Not all suicidal persons are mentally ill.[35] There is unhappiness but few symptoms of severe disturbance. The presence of mental illness appears to vary with age - mental illness is more often associated with suicide in adults and older adolescents.[36] Younger adolescents display psychiatric illness in fewer cases.

Suicidal adolescents seldom exhibit classical symptoms of depression. Adolescent depressions are often masked by moodiness, temper tantrums, running away from home, anorexia, and alcohol abuse.[37] Behavior disorders and sociopathology are also common.[38] These may be shown by truancy, vagrancy, theft, and school phobia. In summary, while many suicidal adolescents do not experience depression or psychoses, they do suffer emotional stress and masked depression. In fact, adolescent suicide is more often due to environmental pressures than with inner stresses.[39] Mental illness can only be assumed when there are irrational reasons given for the suicide.

The association of suicide and mental health is not merely affected by age. The seriousness of suicidal intent is also a factor. Those who threaten suicide are often more disturbed than those who attempt.[40] Those who make repeated attempts demonstrate greater psychiatric illness then those who make a single attempt.[41]

Sex is another variable which influences the association of suicide and mental health. Males tend to demonstrate depression, while females show behavior problems such as hysteria and antisocial acts.[42] Also, male suicide attempters suffer mental illness more often than females.[43] Thus, both the nature and extent of mental disturbance can be effected by the sex of the adolescent attempter. Also, the variable of sex may combine with intent. This is evidenced by the fact that young females who are serious in suicide intent display mental illness as frequently as males.[44]

In conclusion, it may be said that adolescent suicide is precipitated less by endogenic factors than environmental pressures. Where mental illness exists, it will likely be seen in older males, repeated attempters, and committers. Mental illness is exhibited less in suicidal adolescents, and this even includes young males who commit suicide.[45] Environmental stresses and conflict are more common precipitators, and are associated with fewer attempts of lower lethality. However, the liklihood that mental illness caused the act is greater if few environmental stresses exist to explain the suicide.

Locus of Control

An external locus of control is associated with suicide potentiality, accident proneness, and psychological maladjustment.[46] Adolescents with an external locus of control believe that environmental rewards are due to forces outside their control. They are helpless victims of chance as they go through life. In contrast, the adolescent with an internal locus of control feels that what happens to him in life is due to his actions. He is in charge of his life and therefore feels more capable and powerful. Hope is a function of one's sense of competence, so it is easy to see why the adolescent who externalizes control feels helpless and hopeless. When problems arise he may see suicide as the only way out. He is discouraged because he does not see himself as someone who can effect or change life's burdens. All he can do is try to escape them.

Some authors claim that locus of control is not as great a cause of suicide as a shift in locus of control.[47] An example is the dependent child with an external locus who enters adolescence to find society expects him to assume responsibility and independence. He is asked to form an identity and develop a more internal locus of control. Another example would be an independent career woman who marries and attempts to assume the role of a dependent housewife. Both these persons are forced to change their habitual locus of control. This is a highly disorganizing and anxious experience which can lead to suicide.

When one pairs the concept of environmental constraint with locus of control, some interesting hypotheses arise. Low environmental constraints are said to lead to suicide while high constraints produce homicide.[48] Also, we stated that an external locus of control is associated with suicide. However, under conditions where there are few environmental constraints, an internal locus of control can lead to suicide.[49] Suicide results because the adolescent in this situation has no environmental stresses to blame his problems on. He also has an internal locus of control, so he takes responsibility for the traumas in his life. This produces a state of high guilt. In conclusion, the locus of control has a complex association with suicide. We cannot say an internal or external locus of control leads to suicide. We would be better to ask whether locus of control is differentially associated with suicide under varying environmental conditions.

CONCLUSION

There is no such thing as a suicidal personality. In other words, there is no one personality profile which will fit all suicidal persons. We have more luck constructing profiles of subgroups such as the adolescent attempter, the older male committer, or the adolescent committer. Let us sort through the contradictions and confusion of personality research to form a hypothesis of the "typical" adolescent attempter of suicide. The following personality variables might be seen.

1. Impulsiveness.
2. Outward hostility and acting-out.
3. Emotional problems are mild and usually take the form of delinquency, acting-out, and sociopathology.
4. Relationships with others are present, albeit very stormy ones. Conflict makes these relationships unsatisfactory and unhappy.
5. Motives of exogenic stress are common and often involve family, school, and love relationship problems. Motives of grief, bereavement, depression, and other endogenic causes are less common.

6. Students have adequate or average ability. Nevertheless, marks are low. Also, nonacademic problems are abundant and tend to disrupt school progress.

When compared to adolescent suicide attempters, young committers of suicide may exhibit a different personality profile.

1. They are less impulsive.
2. There is a tendency to be intropunitive.
3. Less acting-out and sociopathic behavior are shown. They are often "good" boys and girls - some are referred to as "model" students.
4. Withdrawal and isolation are common - relationships with others are mostly absent. There may be a history of withdrawal which dates from earliest childhood.
5. Depression is often observed. This takes the form of classic depression rather than the "masked" depression of attempters.
6. Intelligence may be superior and marks are often high. However these marks may drop in the weeks or months prior to the act.

Of course, adolescent committers of suicide share personality variables in common with all suicidal adolescents. These are low self-concept, rigid and inflexible problem-solving skills, an external locus of control, active dependence, anxiety, a subjective value orientation, and fewer clinical manifestations of mental illness than adults display.

As we can see, the average suicidal adolescent does not fit our stereotypical picture of the mentally ill, withdrawn, and severely depressed adult. Some exhibit depression but this depression is often masked by acting-out behaviors. Even those who demonstrate classical depression may be overlooked because of the belief that adolescents don't commit suicide. Also, the student who is quiet and withdrawn is usually just labelled "good" because of society's stereotype of what a normal adolescent should be like. Clearly, we need to know more about suicidal adolescents' personalities. There are personality variables associated with adolescent suicide. However, these personality factors may vary with the age, sex, and suicidal intent of the adolescent. Consequently, different personality variables could be associated with various subtypes of adolescent suicide. These hypotheses await research verification. Personality research is an area where knowledge is greatly needed and there are enough provocative clues to warrant further investigation. Until then, we will have to be tentative in our use of personality clues to identify and understand the suicidal adolescent.

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CHAPTER 7

THE FAMILY AND SUICIDE

Researchers have noted that suicides cluster in families.[1] Many suicidal adolescents have known a family member to demonstrate some form of suicidal behavior, and theorists have attempted to explain this provocative finding.[2]

Initially, it was felt that suicide must be hereditary.[3] However, the research studies which support this view often involve cases of manic depressive psychoses.[4] It is probably the psychosis, if anything, that is inherited - not suicidal tendencies.

Also, suicide is too complex a behavior to be a simple inherited trait, untouched by environmental factors.[5] Even if there are some inherited tendencies involved, the weight of environmental factors is so impressive that genetic variables appear negligible by comparison.[6]

Evidence of environmental factors has led many theorists to renounce genetic explanations. They feel that suicide patterns in families can easily be explained by pathological family systems, learning, imitation, and family tensions.[7]

Whatever the reason, adolescent suicide often occurs in the context of impaired family relationships.[8] This is not to say that parents "cause" the suicide of their child. The present chapter is merely an attempt to discuss adolescent suicide as a problem which involves the whole family, and is interactional in nature. In other words, suicidal family relationships will be viewed as involving feedback and reciprocity. Earl Grollman says,

> One must understand the emotional climate of the family before he can understand the individual member.[9]

With these prefacing remarks in mind, some characteristics of the typical suicidal family will be examined. Of course, not all the characteristics apply to all families of suicidal adolescents. In addition, research studies of these families are often merely descriptive and impressionistic in nature, so the results may not be valid or applicable to suicidal families in general. Nevertheless, the following seventeen characteristics of suicidal families are presented as thought-provoking possibilities.

CHARACTERISTICS OF SUICIDAL FAMILIES

An Intolerance for Separation.[10]

Mutual dependence is often seen in suicidal families. Threat of separation from either parent or child may provoke severe anxiety.

Symbiosis Without Empathy.[11]

Though mutually dependent, parent and child show little caring for one another. Hostility or indifference exist despite symbiosis.[12]

A Fixation Upon Infantile Patterns.[13]

These fixations are maintained by the family system. For instance, the adolescent may be told in subtle ways, "Don't go away to school or we'll die." Another message might be, "If you are horrible enough to leave us you deserve to die."

A Fixation Upon Earlier Social Roles.[14]

There may be a preponderance of either passive or brutal fathers.[15] Mothers are often dominant in the family, but infantile and still very attached to their own mothers.[16] The father may often be treated as one of the children in the family; in fact, the parents tend to remain in the role of children by being symbiotically attached to their own parents.[17] In conclusion, we might say that there is a general failure of parental role development.[18]

Closed Family System.

This refers to a family which cannot tolerate any outside contacts that would threaten the established family structure.[19] For instance, if the adolescent gets a new confidant, friend, or fiancé, there is pressure to end the relationship. Such relationships cause conflict between the parents and adolescent. The contact must then be broken to end the conflict and the family once again closes itself off.

Aggression and Death Wishes Directed Against the Adolescent by the Family.

These wishes can be obvious or subtle and nonverbal.[20] In fact, the suicidal person may be less hostile, more quiet, and more inhibited, than other family members.[21] To make the situation worse, the family unit is likely a "closed" one so the suicidal adolescent has no outside allies.[22]

Scapegoating.

Suicidal families have been characterized as "blamers."[23] One person is held responsible for the rest of the family's problems. In scapegoating, the least articulate or belligerent family member serves as the whipping boy for family frustrations.[24] Frustrations can arise from a family death, previous suicide, economic stress, marital disharmony, sibling tensions, or child-rearing difficulties. Scapegoating an adolescent can relieve tensions by focussing family energy on the adolescent and away from other difficulties. The child, in return, gains the importance and negative attention due to the "sick" member of the family. Such negative attention is at least better than being ignored. When the scapegoated adolescent is bad, the usual form of punishment is shunning.[25] In effect, the adolescent is blocked off. This is particularly hard on the suicidal adolescent who is often dependent.[26] Families also use public humiliation, such as criticizing the adolescent in front of friends.[27]

Sadomasochistic Relationships.

Parent and adolescent may alternate between hurting and being hurt.[28] This is a reciprocal process and parent and child alternate roles.

The Suicidal Adolescent is the "Bad Object" of the Family.

This is one aspect of scapegoating. The adolescent is told he is sick, bad, disappointing, or depraved. He may come to believe this.[29]

A Quality of Family Fragility.

Family members feel vulnerable and threatened.[30] Each member also views the others as fragile. The suicidal adolescent is especially perceived as fragile and incompetent and his suicidal feelings are offered as proof of this.[31] Also, the adolescent may believe his parents cannot cope and he is a terrible problem to them.[32] For instance, one suicidal boy felt he couldn't tell his parents about his failure at school or his mother and father would fight again - and he was always causing his parents to fight.

Family Depression.

Depression may be found in the family or its history.[33] This depression can involve the suicidal adolescent and the parents who may have been depressed first.[34]

An Intolerance for Crisis.

Factors which trigger the suicidal act tend to be normal family and adolescent developmental crises that all families experience.[35] These normal events are viewed as terrible because they upset the tenuous family homeostasis.[36] Such "normal" crises might occur when the adolescent starts dating, or begins to talk of leaving home to go to school. The anxiety and family conflict which follow the attempted role change may be seen by the adolescent as vastly out of proportion to the situation.[37] His family punish him for what he considers normal behavior or a minor transgression.

Suppressed Ambivalence.

Members of a suicidal family often feel intensely ambivalent about one another.[38] While this is true of most families, ambivalent feelings are repressed, denied, or hidden in the suicidal family.[39] In fact, hostility, aggression, or frustration are habitually handled in this manner.

Double Bind Relationships.

A double bind relationship results when the suicidal adolescent is given messages to be both close and distant at the same time.[40] For example, consider the mother who subtly clings to her dependent son, yet chastises him for his dependence on her. The adolescent is punished no matter what he does. There is no escape. He can either accept his mother's castigation concerning his dependency, or listen to her tell him he's an awful person who doesn't care about his mother.

High Achievement Demands.

Some suicidal adolescents have high achievement pressure placed upon them by parents.[41] The parents themselves are often achievement-orientated.[42] This, of course, is a normal occurrence unless it is so extreme that it implies parental feelings of inadequacy, failure, and insecurity.[43] If a parent feels this brittle, all adolescent communication which suggests parental failure is screened out.[44] Of course, nothing is more likely to provoke feelings of "where did we go wrong?" than a child's suicide threat. Also, any failure makes the adolescent himself feel terrible for he has frequently internalized parental expectations.[45] The inadequacy is further exacerbated if the parents place high expectations on him, while telling him he is bad and inadequate at the same time.[46] Expressions of unhappiness, frustration, or failure are unacceptable to such parents and may be met with denial, ignoring tactics, or outright hostility.[47] These reactions drive the adolescent to further isolation and even greater desperation.[48]

A Pattern of Reciprocal Causation in Maladaptive Family Relationships.

Suicidal adolescents may set up the conditions for the crises which trigger their suicidal act.[49] As such, suicidal relationships are not caused by parents, but result from the interaction of both parent and adolescent. Through his excessive demands, the passive and symbiotically dependent suicidal adolescent may, in fact, bring about the rejection he has fantasized.[50] Suicidal adolescents can also be more withdrawn than other adolescents, and it is interesting to speculate whether this is a cause or result of rejecting parental treatment.[51] Finally, such parents may not be rejecting, but are merely misperceived as being so by the dependent and excessively demanding suicidal adolescent.[52]

Family Communication Disturbances.

The majority of suicidal adolescents send out clear warnings of their suicidal intentions, which are usually ignored by their families.[53] One study found that, of the 46 percent of suicidal adolescents who reported their intention to others, only half told their families.[54] However, approximately 88 percent of adolescent attempts take place at home, very often with parents in the next room! One author recounts the example of a young woman who was ignored by her husband when she told him she would kill herself. Even as she recounted this in a counselling interview, her husband turned away.[55] In addition to an unusual imperviousness to suicidal communication, there is a general ignoring of the suicidal person as well.[56] Frequently observed family behaviors include deliberate turning of backs and cutting off the suicidal person when he is reacting or talking.[57] It would appear that there is not only a paucity of dialogue in these families, but a stopping of mutual or two-way communication. To make matters worse, communication outside the family is subtly forbidden so the suicidal adolescent is effectively cut off from everyone.[58] In such cases, non-verbal behavior, such as a suicide attempt, may seem the only way of communicating in the home. The rest of this chapter will further explore the nature of abnormal communication in suicidal families.

COMMUNICATION DYNAMICS OF SUICIDAL FAMILIES

A key factor in adolescent suicide is the inability of the adolescent to communicate with others through normal channels, and the inability of others to communicate with him.[59] When compared to adult suicide, adolescent acts are more likely to take place in the context of dissonant interpersonal relationships.[60] Therefore, understanding the dynamics of impaired family communication is vital if we wish to understand adolescent suicide.

What characterizes communication in a suicidal family? Unfortunately, there are no clear answers to this question because there is little research on the subject. However, Paul Watzlawich, Jan Beavin, and Don Jackson have developed an intriguing theory of communication in general. This work may generate hypotheses concerning the nature of communication in the families of suicidal adolescents. Let us now explore what Watzlawick's theory leads us to speculate concerning suicidal family communication.

To begin with, Watzlawick, et al. state that a behavior cannot be understood unless one focusses on the communication relationship or the context the behavior is emitted in.[61] This context involves the signs the adolescent sends, the signs the receiver gives back, and the adolescent's reaction in return. In effect, there is a feedback loop where the behavior that is emitted is met by a reaction, which in turn determines the type of future behavior emitted; communication is not a linear process.

Accordingly, we hypothesize that when adolescents wish to talk about problems, and these pleas are met by denial or rejection, they will find a more drastic means of communicating concerns. Undoubtedly, there are sick families which routinely deny adolescent concerns. However, even normal families may deny such appeals for they provoke feelings of guilt and recrimination in parents. This is particularly true if the parent feels they have contributed to the adolescent's problem, failed to notice distress, or didn't provide help soon enough. Also, we must ponder the extent to which pathological communication between adolescent and adult is sanctioned by society. For instance, worry over failing a biology test, being turned down on a request for a date, or having no where to go on a Saturday night, are all considered 'suitable' problems for an adolescent. However, western society is uncomfortable about allowing these 'quasi-children' adult problems such as existential crises, or suicidal feelings. In fact, adolescents with important concerns may find their messages unheard, denied, ignored, or harshly rejected. Such topics are taboo in adolescent-adult communication and it may take drastic non-verbal messages to break through society's wall of deafness. In this regard, Watzlawick, et al., point out that any seemingly strange and pathological behavior may be viewed as appropriate when placed in the communication context in which the behavior occurs.[62] When all other attempts to communicate fail, suicide attempts may be a logical way to get help.

A second idea discussed by Watzlawick et al., is the concept that all communication has two levels.[63] These are the content and relationship levels.[64] The content level conveys information, while the relationship level concerns what the message says about the relationship between the two people who are communicating.[65] To demonstrate, this writer would like to relate the general gist of a conversation reported by a suicidal adolescent.

Adolescent: I'm just going nowhere. It's like I'm scared because uh...I just don't know who I am. Like I don't know if I'm ever gonna. I just get the feeling that I can't take this feeling much longer, you know.

Parent: I can't figure out what's wrong with you! You've got everything you could ever want...you're a lot luckier than most kids. What more can you want? You're just spoiled! When I was your age I had a job. I didn't sit around like you. We had it a lot rougher. You go out and get a job...that's what you need, instead of sitting here wondering what to do for a job. Go out and get busy at any work and quit sitting around here being lazy and whining about it!

Adolescent: I knew you wouldn't understand. (*This last was muttered quietly out of the parent's hearing.)

What does the above communication say on the content level? It seems the adolescent doesn't know what he wants for a future, an identity, or a career. Both parent and adolescent would agree that the adolescent is upset, he does not have a job, and the parent went to work at an early age. What are these two communicating on the relationship level? To begin with, the adolescent is not confident that his parent will understand him, even before he begins to speak. The parent is perplexed and feels this is another example of the son's whining and lazy ingratitude for the hardworking parent he has been.

It is important to realize that this adolescent's message was not merely heard and then rejected by the parent. If this were the case, the parent would have understood what was said, but perhaps felt that the adolescent was lying about his feelings. What has happened here is a process Watzlawick et al. call disconfirmation.[66] Disconfirmation occurs when the adult indicates that what the adolescent has just said was not merely disagreed with, but was not even heard! The adolescent is told, in effect, that his feelings have no validity. He cannot feel a sense of reality about his thoughts and emotions because they do not exist for others. This is vastly more distressing than having one's communication rejected. A vivid example of communication disconfirmation is given by Herbert Hendin who recounts the story of a suicidal girl named Sandra.[67] After a recent suicide attempt, Sandra dreamed that she had on a pair of blood-soaked jeans and her mother hadn't even noticed! She spoke bitterly of how her mother would never acknowledge hurt or pain in the daughter. Sandra had, in fact, slashed her wrists several times without telling her parents and they never asked even once about her very visible scars!

Watzlawick et al. point out that such imperviousness may exist in one or both parties.[68] Thus, the adolescent may also disconfirm parental communication. In our previous example, the adolescent has not heard the parent's relationship message of caring, hidden by confusion, fright, and guilt. The adolescent has interpreted the confusion, guilt, and fright as meaning a complete lack of caring. Thus, it takes two parties to produce abnormal communication. Some authors speculate that the suicidal adolescent may even set out to evoke or illicit abnormal and rejecting communication from parents or therapists.[69] There can be an inability to tolerate or find positive emotional experiences.[70] Such adolescents will reject caring communication from others.

When parent and adolescent are communicating at cross purposes like this, each is confused when the other doesn't subsequently act according to the message he was thought to have conveyed. The parent who feels his moody and spoiled child is communicating laziness and ingratitude over a mere "adolescent" problem, would be shocked when that child commits suicide. This may explain the bewildered parents and teachers who are surprised by the fact that a quiet and model student would kill himself. Undoubtedly, some guilt and denial are involved in the alleged disbelief. However, part of the shock may be an honest expression of bewilderment from an adult who has blocked out all the "inappropriate" warning messages that the adolescent has sent. Thus, many teen suicides are mistakenly attributed to accidents. Consider the following example of an 18 year old boy who had been jilted by his girlfriend two weeks previously. He had repeatedly told friends and family that he would kill himself. The family was upset but passed it off as adolescent moodiness which was painful for the son, but not serious. That night the son attended a party where he drank about five bottles of beer and met the ex-girlfriend. She again spurned his advances whereupon he left the party after announcing his intention to crash his car and kill himself. Seven minutes later he drove through a bridge at high speed and drowned. The death was considered purely accidental by authorities and family alike. Just another example of those crazy kids drinking and driving!

Communication blockages can also cause adolescents to become bewildered about subsequent parental actions. For instance, one study of suicidal adolescents found that while parents thought they were using appropriate behavior management tactics, adolescents felt this discipline was inconsistent.[71] They felt their parents were too harsh on trivial matters and neglected serious behaviors.[72] They were totally bewildered by parental responses to some of their behaviors. Such confusion often led them into more serious behaviors as a means of gaining parental aid.[73] They were distressed by the lack of communication and consequent lack of understanding of parental reactions. However, it is likely that further attention-getting behaviors only aggravated the situation, rather than bridging the communication gap. When the misbehavior failed to change the situation, the way was paved for a last desperate ploy ...the suicide attempt.[74]

Watzlawick et al. have introduced the concept of communication double binds, which may shed further light on communication styles in families of suicidal adolescents.[75] Such double binds usually occur in intense relationships where both partners have a lot invested in maintaining the relationship at any cost. At this point, it is worth reconsidering the finding that the suicidal parent-child relationship may be stormy and actively dependent.[76] Parents may be critical, demanding, and aloof.[77] There are payoffs here for both parties. The adolescent may postpone independence and the search for an identity. He has an unpleasant but dependent haven to hide in. The payoff for the insecure, critical and guilt-ridden parent may be the fulfillment of a need to have a perfect, "happy" and child-like son or daughter - someone who never grows up and asserts adult-like independence. They also are able to maintain the image of being a good parent. Of course, any signs that the happy child is vanishing have to be blocked.

The double bind would have two results. First, the adolescent wouldn't dare communicate outright conflict with parents. Dissonant communication would have to be subtle and nonverbal. Second, the parent must block, ignore, or reject all signs of imperfection, unhappiness, or adulthood in the adolescent. In our previous example, the adolescent is given contradictory messages of "I care" and "I don't care." The adolescent may want to shout, "you don't care," or "you never listen or understand," but the adolescent in our example doesn't. To do so would be tantamount to "blowing the whistle." The relationship would be threatened. Instead, he chooses vandalism, alcohol abuse, and ultimately a suicide attempt to convey his message. The frightened parent denies the message by labelling the son's problem as laziness and whining. These are "appropriate" problems for an adolescent to have.

As we have seen, double binds are useful in maintaining a relationship that is desired at any cost. Critical and guilt-ridden parents maintain a facade of caring while dependent adolescents preserve the illusion of being nurtured. There is much unhappiness, but at least the relationship is preserved. One way out of a double bind is withdrawal.[78] First, this could involve completely leaving the relationship, but this would mean giving up the payoffs the relationship has produced. Secondly, one could simply walk away and withdraw from the parents as the adolescent in our example did. Here, the adolescent becomes increasingly isolated from others. Finally, if neither of these options remains tenable, and one feels they can no longer tolerate a double bind relationship, suicidal behavior may result. In effect, one either chooses to endure the double bind relationship for its mutual payoffs, or one withdraws. If giving up the relationship is untenable, and isolation becomes unbearable, suicide may seem the only form of withdrawal left. This might be particularly true if one comes from a family where one has seen others use suicide as a form of problem-solving behavior or escape.

A final concept introduced by Watzlawick et al., which is useful to understanding suicidal family communications, is that of homeostasis.[79] The family is a system, and like all systems, must maintain a state of homeostasis. This may be especially true of the suicidal family which some feel has an extreme intolerance for crises and a quality of brittleness.[80] One might suspect that this tenuous family homeostasis would be drastically upset by a child who was "grown up", imperfect, or suicidal. Any messages which threaten the shaky balance must be blocked out or rejected. This may explain the excessive family imperviousness to suicidal communication which was discussed previously.[81]

The adolescent, if dependent, will tolerate the facade so as not to rock the boat. In fact, each partner buys security at the high price of a collusional relationship. Parent and child agree to play unwritten but predefined roles in an elaborate charade. Neither truly gets to know the other but homeostasis is maintained. The cast of players reads: CARING PARENT and MODEL CHILD, in the new production of HAPPY FAMILY! The lines are carefully rehearsed and governed by unspoken rules. It is a deadly serious business, for if one player forgets the rules or his lines, the play is ruined. Sometimes, if the show runs too long, the actor playing the part of model child grows frustrated with his role. He becomes artistically temperamental and difficult to work with. Unfortunately, the last act is often a death scene where our hero, not originally intending to die, does so by miscalculation or desperation.

A FINAL WORD ABOUT SUICIDAL FAMILIES

This discussion concerning the families of suicidal adolescents began with several cautions. First, there is little research available on the subject and what exists tends to be merely impressionistic. Secondly, what we know of suicidal family characteristics may apply only to some families. Finally, there may be more than one type of suicidal family.

Inspection of the research literature suggests that there may, in fact, be at least two different types of suicidal families. One form of family tends to be controlling, demanding, and domineering.[82] This sort of family crushes the adolescent's identity and independence, and the adolescent is left with very low self-esteem.[83] The other type of family is characterized as cold, passive, and emotionally detached.[84] In these cases, the adolescent feels rejected and begins to experience hatred and hostility towards the parent.[85]

Each of these two kinds of families may be linked to different forms of adolescent suicidal behavior. Michael Peck suggests this when he discusses the idea that adolescent suicide attempters come from families that are merely unresponsive to adolescent needs.[86] This parenting might be called passive or detached. On the other hand, adolescents who commit suicide may come from families which actively deny adolescent needs and communications.[87] As such, these families seem more controlling and domineering than those of adolescent attempters. A final difference between families of attempters and committers lies in the variable of mental health status. Research has suggested that the families of adolescent suicide committers contain more mental health problems, for there is a higher incidence of psychiatric hospitalization amongst these family members.[88] This would imply that the families of adolescent attempters are not as severely disturbed.

These findings suggest the possibility of more than one subtype of suicidal family, each producing a different form of adolescent suicidal behavior. This hypothesis is, of course, only tentative but it appears provocative enough to warrant investigation. Previous research on families of suicidal adolescents, has likely masked important differences and complexities because it failed to consider families of attempters and committers separately. Truly enlightening family research results will only occur when this situation is rectified.

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PART THREE

WHAT TO DO ABOUT ADOLESCENT SUICIDE

CHAPTER 8

THE PREDICTION OF ADOLESCENT SUICIDE

The suicide of an adolescent comes like a bolt from the blue. Everyone is shocked and surprised. We are startled because we believe the myth that adolescents don't commit suicide. The shock also arises because we are unaware of the many clues by which the adolescent has desperately signalled his intentions to us.

How do we know if an adolescent intends suicide? When we ask him if he wants to die, we may get an honest answer. However, the person may lie in an attempt to conceal his intentions. Families and adolescents themselves, may deny the seriousness of suicide intent in an effort to avoid facing the emotional and family problems behind the suicide. Finally, the adolescent may simply be ambivalent in his intentions and cannot give us an accurate answer because he is not sure himself whether he wants to die. For these reasons, we need to infer intent from objectively verifiable kinds of clues in addition to self-report of intentions.

Nearly all suicidal persons send out warnings. It appears that those who intend to commit suicide display more warning signals than those who attempt suicide.[1] This may be due to the fact that many attempts are impulsive and less well planned than completed acts. Because most adolescents attempt rather than complete suicide, we can expect fewer clues from suicidal adolescents. Nevertheless, adolescents do send out signals of distress which should be heeded.

Perhaps we feel adolescents give few warnings because we don't recognize, and even discount, the signs. After all, the idea that a significant other intends to kill himself is an extremely threatening thought. It is easier to convince ourselves that we must be mistaken - so we block recognition of these signals.

Many suicidal adolescents have been to a doctor in the year before their attempt, although most have nothing physically wrong with them.[2] Obviously, these adolescents have gone to physicians seeking a different kind of help. We can only provide this help if we recognize when the adolescent is asking for aid. Consequently, physicians, friends, family, and school therapists should be aware of the predictive signs of suicide. Observant teachers can also detect suicide clues because a child who "injures" himself with scissors, or habitually runs in front of cars, is trying to tell us something. We must be particularly alert for the quiet, withdrawn child who is often overlooked in class as being "good."[3]

What are the signals that suicidal adolescents send out? There are essentially four types of predictors of suicide risk, (1) demographic indices, (2) psychological signs, (3) clinical-evaluative information, and (4) data from psychological tests. An explanation of these follows.

DEMOGRAPHIC PREDICTORS OF SUICIDE

Demographic predictors pertain to age, sex, and marital status. They are extremely simplistic and often not very helpful in predicting the immediate risk of one person's suicide. The fact that a man is elderly does not tell us much about his risk in a crisis. However, it does help us identify groups in society who, as a whole, present a high risk of suicide at some undetermined time in the future. When one wishes an assessment of immediate danger, we must turn to psychological predictors.

PSYCHOLOGICAL PREDICTORS OF SUICIDE

There are five kinds of psychological clues which warn of suicide. These include physical signs of stress, verbal messages of intent, behavioral signs, situational predictors, and syndromatic warning signals. Each of these will be explained in turn, beginning with physical signs of stress.

Physical Signs

Suicidal adolescents make frequent visits to physicians and school nurses in the months prior to their act.[4] Their complaints are somatic in nature but are seldom diagnosed as a specific physical illness. Symptoms include back problems, poor appetite, overeating, stomach aches, drastic weight loss, anorexia, insomnia, frequent deep sleep, and failing eyesight.[5] These complaints are warnings and we should always be alert to a sudden rash of unexplained somatic symptoms in a previously healthy adolescent.

Verbal Warnings

Adolescents often give verbal warnings of their suicide intentions, which are usually ignored by others.[6] Many people unfortunately believe the myth that the person who talks about suicide won't actually do it. Some clues are very direct. These include statements like, "They'd be better off without me," "I can't go on," or "I want to end it all." Other verbal clues are extremely indirect, and one has to listen carefully to catch the hidden message. The adolescent might say, "I won't be needing these records any more," or he might ask, "I wonder how many aspirins it takes to kill a person?" Some may say in anger, "I'll never give you a chance to do that to me again!"

If you are suspicious, you can simply ask the adolescent if he has thought of harming himself. Many adolescents will answer this question honestly.[7] They will often be relieved when the subject is in the open and can be discussed. Despite this, we must remember that those who say they have considered suicide, but would never do it, cannot be relied upon. Such a response must be weighed with all the predictive evidence. We must consider other factors along with the client's self-report. Some of these clues can be found in the predictive behaviors the adolescent exhibits.

Predictive Behaviors

Actions such as making a will and giving away possessions may indicate that suicide is in the offing.[8] Previous suicidal behavior is also a sign of risk.[9] As we have seen, casual statements indicate a problem, and when these are not heeded, a suicidal gesture can follow. If this does not bring help, a more serious attempt may be made. Finally, the adolescent may decide to really kill himself. This is why previous attempts must be heeded - they indicate that the adolescent is becoming desperate enough to finally kill himself. Earlier insignificant attempts can therefore mean that a fatal suicide is imminent.

In attempting to evaluate the seriousness of previous or present suicidal behavior, it is useful to examine the adolescent's suicidal plan.[10] For instance, how specific is the plan? Someone who has planned his act down to the last detail represents a higher risk than someone who is very vague. Second, we must consider the lethality of the person's chosen method. Does he plan to use a gun which is almost certain to kill, or take an overdose of aspirin which is less lethal? Third, the availability of the chosen method will also determine risk. A person who plans to kill himself with barbituates, which he has readily available, is at greater risk than a person who plans to use a gun but has no means of quickly obtaining one. On the other hand, we would be more concerned if he had a gun waiting in his bedroom closet. Fourth, the chance of rescue can determine the risk of suicidal behavior. The adolescent who is less serious in his intentions may plan to take a barbituate overdose at 4:45 p.m., knowing his father will arrive home at 5 p.m. A more serious act would be staged at a time and place where the adolescent is sure he will not be discovered. Despite this, some adolescents may stage highly serious suicide acts with people around due to exhibitionistic urges or a desire to hurt others by dying right in their presence.[11] Fifth, the bizarreness of the act should be considered. Strange methods, or arranging for multiple causes of death, can signal severe mental illness. Such disturbance can lead to impulsive, unpredictable, and violent suicides that often result in death.

A final word should be said about the severity of suicides which include an attempt to kill another person. These forms of suicide are always desperate and violent. They are invariably seriously intended, and very tragic if not heeded and stopped in time.[12] Plans to kill another person with themselves are the surest and most ominous sign of extremely serious suicide intentions!

These behavioral signs associated with suicidal plans may prove helpful in predicting the possibility of suicidal intention. Despite this, they are not fool-proof and should never be used simplistically. For instance, some adolescents who are serious in intent may make medically harmless attempts.[13] The suicide plan is only one part of the picture. It should be combined with other kinds of data if we wish accuracy in our predictions of suicide risk. Other kinds of information that we can consider, involve the life situation which the suicidal adolescent is in.

Situational Predictors

Certain events in an adolescent's life warn us that suicide may be near. These are: (1) a death in the family, (2) recent loss of a job, (3) recent discharge from hospital after a previous attempt, (4) recent failure of psychiatric treatment, (5) alcoholism, (6) drug abuse, (7) recent divorce, and (8) a severe family conflict.[14] There are also some stressful situations which involve school. A student who is extremely achievement-oriented, worried about grades, and pushing himself too hard, can succumb to suicide.[15] The risk is particularly great if the student has experienced a recent school failure.[16] Even a slight drop in grades may be extremely upsetting to a student with excessive achievement needs. One should also be watchful of an adolescent who has known a family member, relative, or friend to exhibit suicidal behavior.[17]

Syndromatic Predictors

Certain syndromes of mental illness can increase the risk of suicide. Mental illness will often go unrecognized by the adolescent and those around him.[18] All the adolescent may be aware of is a sense of overwhelming anxiety and panic. If he tries to control his symptoms by making a great effort and fails, he feels a sense of guilt and hopelessness.

He also feels guilty because he has the reactions of others to contend with. They frequently minimize the severity of his problem and his distress. They might even criticize and blame him, all the while advising him to force himself back to normalcy. He will be told to try and enjoy himself again - as if there was no real cause for his unhappy feelings! All this only deepens his sense of helplessness and guilt. Not only can he not control things - he has even become a burden to others! All his efforts to return to normal have failed so there is no hope he ever will get better. Therefore, he is doomed to more of the same intolerable pain he is presently in. He may finally decide that death is the only way out.

Of the different kinds of mental illness, the overtly psychotic adolescent is the easiest to recognize because his symptoms are often blatent.[19] Symptoms can include lack of concentration, poor memory, and agitation. Not all suicidal adolescents are psychotic, but certain kinds of mental illness increase the risk of suicide. For instance, the paranoid adolescent who contemplates suicide is difficult to spot because he can be quiet, withdrawn, and refuse to divulge personal details.[20] He feels persecuted and may be very secretive. Thus, some recommend that all paranoid adolescents be considered suicidal until one knows them well enough to rule out the possibility.[21]

With schizophrenia, suicide risk is greatest in the early stages of the syndrome, when anxiety and panic are at their peak.[22] A diagnosis of manic-depressive psychoses is also a signal of high risk.[23] Signs of manic-depressive illness include an unexplainable or sudden lifting of mood, excitement or euphoria, and sudden calm in a person who was previously agitated.

Depression is also a key predictor of suicide.[24] Even if the adolescent gives no other suicidal communications, we should worry about suicide if he displays a depressed affect, affirms that he feels worthless, believes he is a burden to others, is preoccupied with the subject of death, and feels no hope for the future.[25] There is loss of interest in surroundings and activities, inability to feel pleasure, self-neglect, crying, and loss of sexual desire.[26] Clinicians are wise to investigate the possibility of suicide whenever they detect these symptoms of depression.

Although depression is a valuable predictor of suicide, it is less consistently exhibited by adolescents than adults.[27] When depression is present in adolescents, it is often disguised. James Coleman has referred to this as masked depression.[28] Signs of adolescent depression may differ from the signs of adult depression. These differential signs include sleep disturbances, anxiety, irritability, anorexia, temper tantrums, sudden changes in personality, a sudden decline in school work, and acting out behavior.

The relationship of depression to suicide is not a simplistic one. Those who are slightly depressed, or just beginning to recover from a severe depression, are most likely to attempt suicide.[29] When the person is in the depths of his depression, he may be immobilized and not have the energy to execute a suicide act. Once the depression begins to lift, enough energy may return to allow him the thought of taking his own life.

Throughout this chapter we have discussed signs which teachers, counsellors, friends and family members can use to evaluate suicidal potential. The final portion of this chapter is concerned with more technical means by which psychologists and other mental health professionals can predict suicide. These signs and methods require clinical training. We will also look at evidence from psychological tests and their ability to predict suicide.

CLINICAL AND EVALUATIVE PREDICTION OF SUICIDE

The clinician who wishes to assess risk will need to consider all the various demographic and psychological factors we have discussed so far. In addition, the clinician will utilize his special skills to evaluate clinical factors.

First, the clinician should watch the reactions of the patient after an unsuccessful attempt.[30] If the client appears relieved and grateful that he didn't die, he may present a lower immediate risk. On the other hand, the client who is sullen, enraged, or depressed about the fact he didn't die, may quickly make a subsequent fatal attempt.

Second, the clinician should evaluate the persistence of suicidal feelings.[31] Has the onset of the suicidal urge been recent and transitory, or is it persistent, chronic, and long-enduring in pattern? Clients who fit the latter description have high suicide potential. In summary, the adolescent with a long history of threats, gestures, and attempts presents a high risk of fatal suicide.

Third, the clinician will evaluate the resources available to the adolescent.[32] This requires a detailed case history of the adolescent's background and family relationships. The presence of significant others, their ability to communicate, and their willingness to help must be known. If resources are absent, or exhausted, risk of suicide is high. When family has turned away, friends have left, and school is not going well, the adolescent lacks the necessary supports to carry him safely through the crisis.

Fourth, the nature and sources of stress in the client's life should be examined.[33] The clinician must know what caused and contributed to suicidal feelings because this determines the adolescent's prognosis. If the cause is temporary, transitory, or solvable, there is less need for concern. Long enduring and severe stress signals a higher suicide risk. For instance, risk is high if the adolescent has a history of mental illness, or his family has a pattern of deeply entrenched and pathological dynamics. This client's envirorment is so overwhelming that suicide can readily occur.

A fifth area to explore is the client's motive for wishing to attempt suicide.[34] Irrational motives are danger signals for they are the product of impaired thinking which can lead to sudden and violent suicide. Life style should also be evaluated for this can indicate the client's stability.[35] In this regard, the clinician should explore the adolescent's school history, incidence of mental illness, and any previous psychiatric hospitalization for these can indicate the adolescent's coping skills. The poorer his coping skills, the more likely he will use suicide as a means of solving his problems.

The sixth area to explore is the adolescent's communication skills.[36] Is he able to communicate with his therapist and significant others? The client who remains inaccessible to the efforts of friends, family, and therapist, is a high suicide risk. A particularly dangerous warning is given by the client you suspect is suicidal, but who denies any suicidal urge. Therefore, clinicians should be careful to never allow even slight suspicions of suicide risk to be overruled by a client's denials.

Finally, the clinician must always try to evaluate the adolescent's level of hope.[37] How hopeful is he of changing his environment, his problems, and the behavior of others? Does he have any goals to pursue, and does he think in terms of a future? An adolescent is in trouble when he feels helpless to change his crisis, and sees no future to offer an end to his strife. He has given up - there is no hope left! He is boxed into the present and sees no way out. Exhaustion, failure, and guilt abound. His only means of escape from hopelessness is death. Consequently, it is important to always explore the issue of hope with the client. Absence of hope indicates the possibility that suicide could be imminent.

To this point, we have discussed risk variables which must be evaluated by clinical judgement. The therapist's skills, knowledge and training will certainly help him here. Also, a number of lethality scales have been developed to aid the clinician in assessing risk. These scales include a mixture of the demographic, psychological and clinical variables discussed so far. Examples of the items included in such scales can be found in Table 1. These items have been drawn from a scale devised by the Los Angeles Suicide Prevention Center.[38] Clinicians may find these scales useful in assessing suicidal risk. The therapist may also use psychological tests like the Thematic Apperception Test, Rorschach, projective drawing tests, and others. The use of such tests to predict suicide will now be discussed.

PSYCHOLOGICAL TEST PREDICTION OF SUICIDE RISK

The use of psychological tests to predict suicide has generally been disappointing. These tests cannot provide specific clues which definitely predict suicide. However, the Rorschach, Make-A-Picture-Story Test, Thematic Apperception Test, Minnesota Multiphasic Inventory, and Projective Drawing Tests do provide a means of detecting a client's depressive thoughts.[39] It is also useful to look for signs of isolation, withdrawal, resignation, and constriction in test profiles.[40]

When examining T.A.T. stories, the clinician should look for a lack of contentment and general depression.[41] It is possible that the acting-out adolescent, with masked depression, may drop his facade during these stories. As such, the T.A.T. may provide signals of adolescent depression that would otherwise go undetected. If the clinician is concerned about an adolescent, and wishes to investigate the possibility of suicide further, he may add to the usual T.A.T. procedure. The modification would take the following form: At the end of stories which contain conflict, the clinician should ask the client how the conflict will, or could, be resolved. Particular attention should be paid to themes which contain an inability to see options or an inability to resolve story conflicts. Stories which end with feelings of hopelessness and helplessness should also be carefully examined. Hopelessness is particularly significant if it is displayed in stories suggested by the blank card.[42]

A further word should be said at this point concerning the concept of hope, its relationship to suicide, and its measurement by psychological tests. Aaron Beck has developed a psychological test called The Hopelessness Scale (HS).[43] A copy of this test can be found in Table 2. Although psychological tests are often poor predictors of suicide, this test appears to be a possible exception. It is a better predictor of suicide than tests designed to assess depression.[44] It even appears to predict suicide better than lethality scales, such as the one seen in Table 1.[45]

The Hopelessness Scale's greatest use may lie in detecting the suicide of nondepressed adolescents. An explanation of why this is so follows. Depression does not cause suicide. It is associated with suicide merely because of its foundation of hopelessness which it shares with suicide.[46] Until this time, we have always relied on depression itself to predict suicide. This has made it difficult to predict or explain suicide in younger persons who often exhibit only masked depression, or no depression at all.

The Hopelessness Scale does not rely on signs of instability or depression to predict suicide. It taps the underlying root of both depression and suicide - this is the mediating variable of hopelessness. Hopelessness may exist, and lead to suicide, without being exhibited in the intermediary form of depression. The clinician need not look for signs of depression to predict suicide, because there is a test which reveals the underlying factor of both depression and suicide.

Consequently, the Hopelessness Scale offers the potential of being one of the most sensitive psychometric predictors of adolescent suicide! The test takes only minutes to complete and should be routinely administered to all students that counsellors suspect are in crisis.

Occasionally, projective drawing tests can also provide clues to suicide potential. In particular, the clinician should look for signs of masochism in drawings.[47] Depression may be displayed by small figures, and suicidal impulsivity is sometimes displayed in large, bloated figures.

Psychometric prediction of suicide is more effective if one has previous test data available on a client. For instance, if a school counsellor has a student's earlier T.A.T. test results, he should compare them with a recent profile. The idea is to examine what changes have taken place. If the current test profile shows malignancies, these are not as significant if they also occur on previous testing without the person resorting to suicidal behavior in the interim. There is greater cause for concern if a comparison of the two test profiles indicates that the client's problems are accelerating. These accelerations are particularly ominous if they are in the direction of greater withdrawal, depression, inadequacy, anxiety, passivity, resignation, and constriction. In such cases, the client is entering a crisis which would increase his suicide risk. A client who has always been anxious, and has not attempted suicide, has likely learned to live with his discomfort. The client experiencing such problems for the first time, or a sudden increase in problems, is more likely to be in a panic.

In general, lethality scales are the best predictors of suicide.[48] Psychological tests cannot match their accuracy, and are best not used specifically for this purpose. The one exception to this is the Hoplessness Scale. If psychological tests are expected to assess risk, they will have to be supplemented with demographic and clinical data.

Lethality scales are better predictors than psychological tests because they utilize overt behaviors, such as suicidal plans, to predict suicide. Psychological tests rely on vague intermediary concepts like impulsiveness and depression, which are not as directly linked to suicidal behaviors. Intermediary variables don't predict suicide as accurately. In addition, suicide is a heterogeneous behavior which may involve impulsiveness, hostility or depression in a conflicting manner. For example, some suicides are inwardly aggressive, while others are outwardly aggressive. Therefore, we cannot expect to establish a single psychological variable that will predict all suicides! If suicide were a homogeneous behavior with only one underlying dynamic similar antecedent and circumscribed response, we would have much more accuracy in prediction.

The use of psychological tests to predict suicide could also be improved if predictive signs were refined. For example, we need to ask what test data predict suicide in specific groups such as men, women, adolescents, adults, attempters, threateners, committers, Orientals, Europeans, and so on. We also need to stop using hospitalized or psychotic suicidal persons to establish psychological preditors of suicide. Such persons likely have different psychological profiles than the average suicidal high school student. Thus, test results cannot be generalized from such an unrepresentative population.

Finally, much of the research concerning psychological tests is essentially test-orientated. Authors of such tests attempt to demonstrate the usefulness of their test rather than its ability to predict an occurrence like suicide. Lethality scales, on the other hand, are task-orientated. Their purpose is solely to predict suicide. Perhaps task orientated research can add items to psychological tests that pertain specifically to suicide. This would increase the ability of psychological tests to predict suicide.

We should not shelve the idea of using psychological tests to predict suicide. More and better designed research may yield promising results. Until such time, clinicians will have to be cautious when using psychological tests to predict suicide, and it is best to use lethality scales if prediction is all that is desired.

Perhaps the idea of using psychological tests to predict suicide has been misguided, and we have overlooked the real purpose of such tests. First, the usefulness of psychological tests lies in their ability to help us understand the suicidal adolescent, as opposed to trying to predict his suicide. For instance, one Kinetic Family Drawing will not tell us whether a 15 year old will commit suicide within the next week. However, it can reveal more about the pathological dynamics of his family, that produce the suicide urge, than we may discover in a whole series of interviews!

Second, psychological tests may enable a school psychologist to evaluate the suicidal adolescent's ego strength, self-concept, his view of the environment and significant others in it, and his capacity to interact with others. This data is not predictive in itself, but offers valuable supplemental information. Test data can be paired with demographic, psychological and other sorts of predictors to increase one's ability to foresee suicide. Thus, psychological tests can never replace clinical judgement, but they do provide information that broadens the therapist's view of the adolescent and his problems.

Finally, what a clinician derives from a projective test will depend on his skill with the test and his knowledge of suicide. Despite negative research findings, a skilled clinician with a good understanding of suicide may find psychological tests highly predictive in his own practice.

CONCLUSION

Throughout this chapter we have discussed predictors that signal the potential of suicide. It is believed that clinicians must consider most of these factors if they wish to increase their predictive accuracy. A clinician needs to weigh demographic and psychological signs of risk as well as factors that require clinical judgement, such as a client's stability or communication skills.

Lethality scales and psychological tests can help round out the picture. Some tests, such as the Hopelessness Scale, are a particularly welcome addition to any counsellor's sources of predictive ability.

Table One: Predictors of Suicide Lethality

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1. Age and Sex

   Male
   - 50 plus
   - 35-49
   - 15-34

   Female
   - 50 plus
   - 35-49
   - 15-34

2. Symptoms

   Severe depression: sleep disorder, anorexia, weight loss, withdrawal, despondency, loss of interest, apathy

   Feelings of hopelessness, helplessness, exhaustion

   Delusions, hallucination, loss of contact, disorientation

   Compulsive gambling

   Disorganization, confusion, chaos

   Alcoholism, drug addiction, homosexuality

   Agitation, tension, anxiety

   Guilt, shame, embarrassment

   Feelings of rage, anger, hostility, revenge

   Poor impulse control, poor judgment

   Frustrated dependency

   Other (describe):

3. Stress

   Loss of loved person by death, divorce, or separation

   Loss of job, money, prestige, status

   Sickness, serious illness, surgery, accident - loss of limb

   Threat of prosecution, criminal involvement, exposure

   Change(s) in life, environment, setting

   Success, promotion, increased responsibilities

   No significant stress

   Other (describe):

continued:

Table One, continued:

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4. Acute Versus Chronic
   - Sharp noticeable, and sudden onset of specific symptoms
   - Recurrent outbreak of similar symptoms
   - No specific recent change
   - Other (describe):

5. Suicidal Plan
   - Lethality of proposed method - gun, jumping, hanging, drowning, knife, pills, poison, aspirin
   - Availability of means in proposed method
   - Specific detail and clarity in organization of plan
   - Specificity in time planned
   - Bizarre plans
   - Rating of previous suicide attempt(s)
   - No plans
   - Other (describe):

6. Resources
   - No sources of support (family, friends, agencies, employment)
   - Family and friends available, unwilling to help
   - Financial problem
   - Available professional help, agency or therapist
   - Family and/or friends willing to help
   - Stable life history
   - Physician or clergy available
   - Employed
   - Finances no problem
   - Other (describe):

7. Prior Suicidal Behavior
   - One or more prior attempts of high lethality
   - One or more prior attempts of low lethality
   - History of repeated threats and depression
   - No prior suicidal or depressed history
   - Other (describe):

continued:

Table One, continued:

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8. Medical Status
   - Chronic debilitating illness
   - Pattern of failure in previous therapy
   - Many repeated unsuccessful experiences with doctors
   - Psychosomatic illness, e.g., asthma, ulcer, etc.
   - Chronic minor illness complaints, hypochondria
   - No medical problems
   - Other (describe):

9. Communication Aspects
   - Communication broken with rejection of efforts to reestablish by both patient and others
   - Communications have internalized goal, eq., declaration of guilt, feelings of worthlessness, blame, shame
   - Communications have interpersonalized goal, e.g., to cause guilt in others to force behavior, etc.
   - Communications directed toward world and people in general
   - Communications directed toward one or more specific persons
   - Other (describe):

10. Reaction of Significant Other
    - Defensive, paranoid, rejected, punishing attitude
    - Denial of own or patient's need for help
    - No feelings of concern about the patient; does not understand the patient
    - Indecisiveness, feeling of helplessness
    - Alternation between feelings of anger and rejection and feelings of responsibility and desire to help
    - Sympathy and concern plus admission of need for help
    - Other (describe):

Table Two: The Hopelessness Scale

Item		Answer Key
1.	I look forward to the future with hope and enthusiasm.	F
2.	I might as well give up because I can't make things better for myself.	T
3.	When things are going badly, I am helped by knowing they can't stay that way forever.	F
4.	I can't imagine what my life would be like in 10 years.	T
5.	I have enough time to accomplish the things I most want to do.	F
6.	In the future, I expect to succeed in what concerns me most.	F
7.	My future seems dark to me.	T
8.	I expect to get more of the good things in life than the average person.	F
9.	I just don't get the breaks, and there's no reason to believe I will in the future.	T
10.	My past experiences have prepared me well for my future.	F
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	T
12.	I don't expect to get what I really want.	T
13.	When I look ahead to the future, I expect I will be happier than I am now.	F
14.	Things just won't work out the way I want them to.	T
15.	I have great faith in the future.	F
16.	I never get what I want so it's foolish to want anything.	T

continued:

Table Two, continued:

Item		Answer Key
17.	It is very unlikely that I will get any real satisfaction in the future.	T
18.	The future seems vague and uncertain to me.	T
19.	I can look forward to more good times than bad times.	F
20.	There's no use in really trying to get something I want because I probably won't get it.	T

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CHAPTER 9

INTERVENING IN SUICIDE

In Chapter 8 we discussed ways of discovering who is suicidal. Once we suspect that a person will attempt suicide, what do we do with him? This chapter will provide some answers to this question.

Actually, there is no one type of therapy best suited to treating suicide. Just as there are different kinds of suicidal adolescents, there are different therapies needed. For instance, suicide intervention for a delinquent adolescent would differ from that suited to a depressed adolescent. As such, the type of treatment offered will depend on the psychiatric diagnosis and individual problems of each suicidal adolescent.

Although therapies may differ, they share some common approaches. First, psychological counselling is given. Second, the adolescent may be removed from the scene of his conflict, such as the home. Third, if the adolescent is not removed from the scene of his problems, there is usually some effort made to manipulate his environment so it is a better place for him to be. For example, the counsellor may attempt to change family or school dynamics.

Finally, the adolescent is aided in restoring lost object relations so his isolation from others is ended.

In the past, intervention techniques for suicide have often been unsuccessful because therapists have considered suicide a discrete disease entity. They develop a specific single treatment for all suicides, such as a new antidepressant drug, and then expect the problem to disappear. It seldom does, and will not, until we relize that suicide is not a single entity. It is merely a sign of various underlying problems. There is no single cause of suicide, so there cannot be any one treatment that will work alone with all cases. The secret of effective therapy is a broad program of intervention that touches many facets of a person's life. Such an approach might include individual therapy, family therapy, group therapy, pharmacotherapy, and other treatment strategies. Therapy will also have to be highly individualized as no suicidal person has the same problem, though we label them all "suicidal."

The first job any counsellor, school psychologist, or other therapist has, is that of assessing the suicidal risk of his client. Until he has assessed risk, the therapist cannot decide whether to refer the patient to a hospital, a psychiatrist, or to see the client on an outpatient basis in his office. He can only choose the last of these alternatives if the risk of suicide is moderate or low.

Assessing risk is not an easy task. Pediatricians tend to underestimate suicidal intent and underlying conflict, while psychiatrists tend to overrate severity of intent and underestimate the adolescent's self adjusting abilities.[1] A happy medium must be found between these extremes. If risk is underestimated, the adolescent may resort to further attempts to get the help he needs. When risk is overestimated, there may be an insistence or prolonged therapy, which can have a detrimental and degrading effect on a client who feels he merely needs some guidance to cope with his problems in an independent fashion. He may also be frightened of prolonged depth therapy because of the size or nature of the conflict which may be dredged up. He may not be ready or willing to expose this to himself, his parents, or his therapist. In the end, he may use excuses and missed appointments to avoid therapy which is too intense.

As can be seen, accurate evaluation of suicidal risk is a key factor in deciding whether or not to refer the adolescent to a hospital or treat him in the office. If the therapist decides to treat the adolescent in his office, he must also evaluate risk in order to decide on the nature and depth of treatment. But how does one measure risk?

The many clues and signs discussed in Chapter 8 will certainly be helpful here. In addition to considering these predictive signs of risk, the therapist will have to consider many other factors. For instance, suicides of schizophrenics and psychopaths are very unpredictable.[2] The more mentally ill or impulsive a person is, the greater suicide risk he presents. This makes such cases difficult to see on an office or outpatient basis. However, impulsive suicides do respond well to in-office support therapy if the therapist is willing to take this risk.[3] Many clients with endogenous sources of depression do not respond well to suggestion and encouragement and may need pharmacotherapy and other procedures available in a hospital.[4] Psychopaths rarely seek help unless it is forced on them.[5] In addition their attempts may be violent and therefore highly lethal.[6] They, and other severely disturbed adolescents, are poor candidates for treatment based solely in an office. Their suicide risk is too great and a school therapist cannot provide the intensive special procedures and carefully controlled milieu found in a hospital. However, psychotherapy can reduce the frequency of repeated attempts and the recovery time from each attempt.[7]

Adolescents in confusion and panic, who deny significant others, are poor risk for office therapy when compared to those who have maintained an adequate social life.[8] Chronic and persistent life stress also indicate a poor prognosis, while a temporary and acute crisis can often be handled in the office. In this respect, it is helpful to evaluate the adolescent's environment. A difficult life situation and poor family support may necessitate hospitalization merely to remove the adolescent from a suicidogenic environment. Family cooperation and involvement is vital to any out-patient therapy. Thus, family attitudes that minimize the adolescent's suicide potential, sabotage therapy, and direct anger at the child for the trouble and disgrace he has caused, contraindicate office therapy. Such family attitudes may be more prevalent with adolescent than adult suicides, necessitating hospitalization more often with suicidal adolescents.[9]

During a session with a suicidal client, the therapist will form opinions regarding the client's response to therapy. If there is rapport, openness, and willingness to accept help, the adolescent will likely respond well to office therapy. On the other hand, office treatment is risky if the client remains inaccessible to interpersonal contact, attends sessions sporadically, and remains uninfluenced by favorable changes in his life situation.[10] He could well harbour suicidal thoughts and plans without the therapist's awareness. He also remains untouched by typical out-patient attempts at contact and therapy.

In addition to all this, the therapist should consider how the client feels about hospitalization. Does he view the hospital as a relief and a haven, or does he fear it and regard it as a sign that he is crazy or incapable? Is he feeling disappointed, ashamed, rejected and abandoned by his therapist? If so, hospitalization can be seen as a sign of personal failure or an indication that the therapist cannot cope because the problem is too great. In these cases, hospitalization can actually increase feelings of worthlessness and hopelessness.

Finally, the therapist will have to evaluate his own ability to cope with the client on an out-patient basis. He should consider his knowledge of suicide and his ability to deal with the anxiety that will arise from his decision not to hospitalize the adolescent. He will also need community resources and the support of co-therapists, for he cannot consider doing office therapy without these additional services and advice. Suicide therapy is too difficult to handle without this support. Neither the client or the therapist benefit when these supports and services are not available. Thus, office therapy is not feasible without this help. Above all, the therapist must consider his caseload before taking on a suicidal client as an out-patient. In general, a therapist should have no more than one to three suicidal clients at a time, or he will be overburdened - suicide therapy is simply too demanding! Additional clients should be referred.

In summation, office therapy can offer the possibility of greater rewards for the adolescent, but is more taxing for the therapist. It is safer to refer the adolescent to hospital, but this isn't always the most productive course to take. Ideally, suicidal adolescents should be referred to hospital only when risk is high and other factors contraindicate office therapy. A psychologist well trained in suicide can handle cases of mild and moderate risk while referring only seriously depressed and high risk cases to hospitals.[11]

Hospitalization can even be detrimental in some cases. First, the suicidal adolescent becomes very passive. Things are done for him and he is not active in his treatment. In the office, he is encouraged to solve his own problems so he learns confidence and self respect. Second, hospital treatment often does not involve the client's environment in the intervention.[12] Consequently, the adolescent is discharged into the same environment which contributed to his suicide in the first place. Thus, it is not surprising to learn that half the suicidal patients who make a second attempt do so within ninety days of being discharged from hospital.[13] In office practice, this situation cannot occur as frequently because one has to work with the adolescent's family, friends, and environment right from the start. Of course, this discussion does not mean one should not hospitalize some suicidal adolescents. Ideally, hospital and office visits should be complementary phases of treatment.[14] The school counsellor should see the adolescent prior to hospitalization, keep track of his progress during hospitalization, and then continue follow-up therapy once the adolescent is released. Here, the school counsellor, psychiatrist, hospital staff, family, and friends all work as a team. All cooperate and keep abreast of what each is doing with the client. Because of this, therapists are now using hospitalization as little as possible, avoiding it whenever they can,and making it brief when required.

So, now you have a suicidal adolescent in your office that you have decided not to refer. What do you do with him? There are no easy answers, but there are general guidelines which may help you devise treatment procedures. The first of these suggestions concerns the therapist's general orientation and attitude toward therapy.

GENERAL ORIENTATIONS TOWARD SUICIDE THERAPY

The feelings a therapist has toward suicide and suicidal persons will determine his effectiveness as a therapist. Frequently school counsellors and other therapists hold attitudes which hinder their ability to work with suicidal students. Let us examine some of these orientations.

Anyone who works with suicide needs to hold the belief that suicide is a communicative, problem-solving, and adaptational act. It is not a manipulative or sly means to bother others. It is a legitimate cry for help and an attempt to change an intolerable life situation. To view suicide any other way puts the adolescent in a lose-lose situation as soon as he reports that he tried to kill himself.[15] For example, one wonders if he really tried to kill himself, then, why is he alive? Often the answers that arise are not helpful. For example, maybe he thinks he wants to kill himself but is in error. Here the therapist subtly conveys to the client that he doesn't believe him and he would be wise to not believe himself. In other words, his thoughts and feelings are wrong and have no validity. Another answer might be that he did intend to kill himself but failed in the attempt. He would be particularly incompetent if his method was nonlethal, when he really had intended to kill himself. Now he feels even more worthless and hopeless than he did before he sought help. Finally, the therapist may decide the client didn't want to kill himself but is making it look like he did. The therapist feels he is being manipulated because he does not grasp the idea that suicide is usually a communicative, rather than death-orientated behavior. The therapist thinks, "If he didn't die, he's just trying to put one over on me!" Naturally, the therapist becomes angry and treatment is developed from an expectation and readiness to counter manipulation. Until therapists realize that the purpose of the suicide is not to kill oneself, but to seek communication, change and help, therapists will convey harmful messages to clients during therapy. The client will be subtly told, that because he did not die, he must be incompetent, misguided in his intentions, or trying to trick the therapist. This will not produce helpful intervention! The adolescent may be impelled to make another attempt to try to get his real message across. Unfortunately, he may die the next time. Therapists who perceive the true message of suicide,and respond accordingly, reduce the likelihood of future attempts.[16] When future attempts do occur, they are likely to be of lower lethality.[17]

Ari Kiev has suggested that the usual model of psychotherapy, where the therapist emphasizes the client's role and responsibility for his problems, seems to increase guilt and helplessness in suicidal clients. When treatment is unsuccessful, the client feels guilty because he could not make the treatment work. It is just one more thing which he has failed. Kiev recommends a medical model of symptoms and illness. This reduces client guilt and takes responsibility off the therapist, for when treatment doesn't work, it is the "medicine" that is wrong. Here, the therapist conveys to the adolescent that his only responsibility is to be open and sincere. The therapist also makes it clear that he is not going to "cure" the adolescent; his job is merely to be knowledgeable about the problem and implement various techniques (medicines) which may work.

Therapists should also beware of an omniscient and omnipotent view of their power over suicide. No therapist alone ever "saves" a suicidal patient, nor is he completely responsible for the client who kills himself. Many favorable results in therapy are due to the efforts of family, friends, community resources, chance, and the client's own ability to pull himself out of crises. A client's death may result from pervasive social forces, firmly entrenched family dynamics, lack of community prevention programs, and lack of therapy resources. These are things that a single therapist cannot fight. An effective therapist is one who realizes his helplessness, and has the ability to comfortably accept this state while doing all he can for the client with the resources he does have.

A therapist must also learn to recognize the negative emotions he will experience with a suicidal client. These include frustration, anger, anxiety, ambivalence, fear, and immobilization.[18] These emotions are a natural consequence of suicide therapy because the chronically suicidal adolescent can be dependent and demanding. He quickly exhausts the resources of family, friends and therapist. In addition, the suicidal adolescent may set out to provoke anger and rejection in the therapist in an effort to reinforce his perception of not being cared for. Possibly, he projects the idealized but hated parent onto the therapist.[19] Others fear growing close to the therapist and will attempt many maneuvers to distance themselves. One suicidal adolescent, fearful of beginning therapy, stated, "I thought I'd try one session to see what you can do for me. If this doesn't work, I'm going to kill myself." Therapists can counter the anger and ambivalence resulting from such "testing" maneuvers by expecting and understanding what is happening - why the client is doing it. Then can they truly give the adolescent the acceptance that he is searching for.

Fear and frustration are also common when working with suicidal clients. Fears arise from feelings of inadequacy during therapy. There are doubts about whether you've assessed risk properly, or whether you are using the right approach. The therapist may fear taking responsibility for his own decisions. Fear can make a therapist ineffective, for he may miss small clues a client sends out. His fear and helplessness may also cause the client to become discouraged and lose hope. Suicide could then result. Therefore, it is important that therapists be calm and convey a sense of optimistic prognosis to clients. But how does a fearful and immobilized therapist do this?

There are ways to overcome the anxiety. First, the therapist should have a colleague share treatment decisions and responsibility for the client. Community resources should also be used wherever possible, for it is better for the therapist and client when others are involved in treatment. It is an unfortunate situation when one "expert" has sole responsibility for a suicidal client. Therefore, school counsellors should call upon school psychologists, teachers, administrators, psychiatrists, experts in the field of suicide, and the adolescent's family. Consultants, referrals, and resource services will greatly relieve the burden. Therapists should also learn more about suicide. For instance, you can feel more reassurance in predicting risk, or planning therapy, if you know what the predictive signs of suicide are, and have a good understanding of suicide. If you are feeling inadequate, make sure this feeling has no basis in reality!

Suicide therapy can evoke frightening feelings in the therapist.[20] Suicidal clients can reactivate old conflicts and fears of the self being suicidal. The therapist thinks that if a bright and attractive adolescent can commit suicide, then he himself could do it. Also, it is easy to become depressed when dealing with suicidal clients. The therapist must understand himself very well to deal with conflicts and depression. Where are the conflicts coming from? Why is he feeling this way? Sometimes counselling for the therapist can help and should be sought if necessary.

Therapists should avoid making value judgements of the adolescent's chosen mode of coping with his problems. Therapists must accept suicide rather than thinking, "If I had his money I wouldn't kill myself. How could he?" Therefore, instead of voicing denials like, "You're not suicidal are you?" a therapist should be accepting and say, "You seem so unhappy, I wonder if you've thought of suicide?" In this manner, the therapist can understand how the adolescent came to choose suicide and then explore more effective means of coping. Accepting suicide does not mean liking it. One can respect the adolescent's right to die while at the same time holding the opinion that help should be rendered. The adolescent isn't in any position to make the decision until he has explored options. The counsellor does not forbid suicide, but asks the client to delay his decision while therapy proceeds.

Sociocultural stereotyping is another pitfall of suicide therapy. For instance, statistics reveal that adolescents seldom commit suicide and that young females are least likely to do so.[21] It is helpful to know sociocultural facts about suicide. However, they must never be used simplistically, for not all suicidal clients fit statistically-established patterns. Some female adolescents do commit suicide too!

Therapists may have fears concerning client confidentiality and therapist protection from lawsuits. To counter this, therapists should know the laws concerning suicide and ethical practice. They should be clear about the rights of client and therapist. They should also advise the client of them in the first session. For instance, if the therapist usually advises a friend or family member concerning serious suicide intentions, the client should be aware of this. As far as protection from lawsuits is concerned, ethical therapy practices offer the best prevention. Therapists should also keep extensive and meticulous case notes of all suicide therapy sessions. In this manner, the therapist is reassured that no misunderstanding of his intentions or therapy practices will arise. Of course, lawsuits seldom arise. Such precautions are more intended as a "security blanket" for the therapist.

Finally, therapists should present a calm, relaxed, and competent demeanor at all times. This should never be pushed to the extent of falseheartiness or joviality, for this is naturally obnoxious to a depressed and troubled adolescent. Clients prefer calm reassurance from therapists. Therapists can give this calm reassurance only when they have dealt with the sources of inefficiency which have just been discussed. It also helps to leave plenty of time for the interview if you are expecting a suicidal client. Clear your schedule so you can devote yourself totally to the problem at hand. If a suicidal adolescent appears without warning, all appointments should automatically be cancelled. It is too hard for a school psychologist to devote himself to the problem at hand when he must be at another school in forty-five minutes! School personnel must know that any demands they have on a school therapist's time will automatically be delayed while the therapist deals with the suicidal student. Certainly, the school system has no more pressing business for a therapist than meeting with a suicidal student.

So far, we have discussed attitudes toward suicide therapy. Therapists must know what orientations hinder or help their work with suicidal adolescents. Self awareness is necessary because counsellors must always monitor their feelings and attitudes in suicide therapy. Suicide therapy naturally produces attitudinal problems. While problems are expected, they can, and should, be dealt with. The suggestions in this chapter will hopefully help therapists deal with unhelpful attitudes.

The therapist's orientation has been discussed at length because it is a vital part of any therapy a counsellor uses with a client. Before considering specific therapy interventions, it is helpful to review general approaches to suicide therapy. These will be discussed in the next section.

GENERAL APPROACHES TO SUICIDE THERAPY

A therapist has many counselling techniques at his disposal when dealing with suicidal clients. Regardless of method, most sucide therapies share common features. These therapies will also differ from "regular" therapies in three important respects. The first difference concerns confidentiality. While confidentiality is observed in all other respects, the therapist does not keep the patient's suicide intentions secret. The client's intention to kill himself is immediately conveyed to significant others although other aspects of therapy remain confidential. The therapist must tell others if he feels the client's life is at stake. Also, significant others are often involved in the therapy because the dynamics of suicide are often dyadic and involve family and friends. Finally, therapists are often more direct and active in suicide therapy than they would be with other problems.[22] This is particularly true in the initial or crisis stage of suicide therapy.

Here the therapist may give direct instructions to the client like telling him to hand over his bottle of pills or go voluntarily to hospital. He may voice approval or disapproval of certain client actions and take a firm stand on some issues. Only after the crisis has passed does he become nondirective.

There are three basic stages of suicide therapy. These are the acute, convalescent, and recovery phases. In the acute phase the therapist protects the client, relieves anxiety, and deals with the client's hopelessness. Protection may involve taking the adolescent to hospital or asking him to hand over his bottle of pills. The client will be anxious because the suicide attempt is often an aggressive act directed against a significant person in the adolescent's environment. Thus, the client may experience fears of rejection or retaliation from that significant person.[23] He may also feel guilty and worthless for doing such a "shameful" thing. To relieve anxiety, the therapist should convey to the adolescent that his actions were not terrible or cowardly, but an attempt to deal with a problem. The therapist can also hold out the hope that solutions other than suicide can be found,once the difficulties that precipitated the act are dealt with in therapy and the adolescent has reexamined the situation.

During the acute stage it may be necessary to see the client as often as once a day, if only for a short time. Become active and directive in treatment and offer support and reassurance. Generally speaking, problems are not probed too deeply in the initial phases of treatment. It is better to delay deep therapy until the client is somewhat recovered.[24] Helping the client deal with his feelings about the act and building hope are more appropriate tasks in the initial therapy.

The convalescent phase sees the beginning of deeper psychotherapy.[25] The cooperation and involvement of relatives is vital at this time because their unconscious attitudes of rejection and denial can be aroused and lead to sabotage of therapy.[26] This is particularly expected if the adolescent begins to express his feelings of being unwanted and unloved. The therapist will have to help everyone work this through.

Problems arise during psychotherapy with adolescents because they often lack insight. Thus, they may deny the seriousness of their problems or blame them on others. This means the therapist must begin to renounce his initial directive stance and allow the suicidal adolescent to assume responsibility for his life. The adolescent may also balk at facing his pain and despair during this phase of therapy. Thus, therapists should avoid premature interpretations that would frighten the adolescent away from therapy.[27] The rule here is, "Slow and steady wins the race."

Transference will usually occur during the convalescent stage of therapy. Dependent transference should be a temporary phase or therapy will be needlessly held up.[28] Countertransference can also occur and the therapist should be alert for feelings of hostility, impatience, and rejection toward the client.[29] There may even be wishes that therapy could be interrupted. These feelings can be worked through with a colleague or consultant.

If the convalescent stage of therapy successfully produces insight, the therapist may have to help the adolescent face a period of depression.[30] This can be done in several ways. First, the self-limiting nature of depression should be explained to the adolescent. He may be relieved to know it will pass of its own accord in two to four months at the most. It may also be necessary to help the adolescent draw up a simple daily routine.[31] However, he should not be prematurely pushed into a high level of activity. The therapist should also explain that suicidal thoughts are common and understandable during depression. To know that such thoughts are not abnormal may give the adolescent a sense of relief and provide an invitation to discuss them with the therapist. Finally, if the depressed adolescent tends to turn anger against himself, it is important to limit the degree of anger aroused until therapy has progressed and the client has more control.[32] Of course, school counsellors and psychologists should refer depressed adolescents to physicians and psychiatrists for antidepressants if necessary.

The final phase of therapy is that of recovery.[33] If the adolescent has been in hospital, he is now back home where his problems began. If he has been away from school with a severe depression, he has returned to classes. Everything appears fine - but before you breathe a sigh of relief - wait! Reactivation of suicidal feelings, gestures, and attempts occur in about ninety percent of cases during this stage![34] About four-fifths of these reactivations happen on a day or overnight visit from hospital.[35]

If the convalescent phase has produced a close client-counsellor relationship, and the client has a good understanding of his previous attempt, the reactivation symptoms may be mere benign fantasies and slight gestures.[36] This reactivation demonstrates how important it is to work with the people in the client's environment, as well as with the client himself. Successful management of the recovery and reactivation phase is probably the most important job of suicide therapy. Reactivation may even be a necessary part of the working-through process, and can lead to greater insight if the client has been well prepared in the convalescent phase.

In this chapter we have discussed general orientations, attitudes, and approaches which can be useful during therapy with suicidal adolescents. The next chapter will continue the topic of intervention, but with an emphasis on more specific techniques. Topics will include crisis intervention, pharmocotherapy, family therapy, and group therapy.

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CHAPTER 10

SPECIFIC INTERVENTION TECHNIQUES

The previous chapter discussed general approaches to suicide therapy. These guidelines apply to all forms of suicide therapy, regardless of the specific techniques chosen. Having explored these general guidelines, let us now devote some time to the discussion of specific strategies for managing suicidal adolescents.

During initial interviews with the suicidal adolescent, it is wise to collect as much information as possible about the problem. School records will supply some data. However, this sort of information is less important than what the adolescent tells us about his situation. To begin with, it is helpful to enquire about the adolescent's background. Areas might include family, school, recent or past traumatic events, illness, etc. Second, it is important to learn all you can about the adolescent himself. The therapist will form opinions concerning the adolescent's self image, attitudes, anxiety, depression, level of maturity, coping mechanisms, defenses, and other personal information. Third, it is important to find out what was happening in the person's life just before they considered suicide. Fourth, the therapist must evaluate what resources the adolescent has available to help him solve his problem. For instance, does he have the support of family and friends? Also, the adolescent's inner resources must be examined. These include psychological resiliency and any defenses. Finally, it is crucial to evaluate the adolescent's feelings about, and plans for, the future. The therapist must know if the client has any hope left, any meaning in life, and any future goals for living.

There is certainly more information that therapists will wish to gather concerning their clients. However, these previous five sources of data represent the essential things counsellors must know to truly understand their suicidal clients. This information is crucial in planning and implementing therapy strategies. One technique that is useful in the early stages of suicide management is that of crisis intervention.

CRISIS INTERVENTION

When a suicidal adolescent first walks into a counselling office, he is confused, panicky, and disorganized. In short, he is in a crisis. Specific techniques have been developed for intervening in crisis situations. The process of crisis intervention will last from approximately one to six sessions. Some adolescents will recover through crisis intervention alone. Many others need deeper therapy. However, therapy should not be started until crisis intervention is completed and the adolescent is feeling better. The aim of crisis therapy is to build hope, encourage the client to find an adaptive solution to his current problem, and limit any exacerbation of earlier neurotic conflict.[1] As such, the client is encouraged to work on derivative problems rather than basic conflicts. Deeper conflicts can be handled in long-term psychotherapy following crisis intervention.

There are several phases in crisis intervention. These will be explained as follows.

1. Establishing Rapport

It is crucial that the therapist quickly build rapport and trust with a suicidal client - he won't be back again if this does not happen! Unfortunately, it is difficult to establish rapport with suicidal persons because they are often fearful or ambivalent about seeking help. They may even engage in "testing" behaviors. Also, the therapist's own fear, anger and feelings of inadequacy may interfere with rapport. Despite this, some things may build trust. These include being honest, dependable and accepting with the client.[2] The counsellor must convey hope, optimism, and the ability to help. It ofen helps to come right out and ask the client if he has considered suicide. Allow the client to discuss his suicidal feelings, and accept these emotions. To deny them, stop discussion of them, or give false reassurances, will only block communication. It is also wise not to begin the initial session with a premature barrage of questions such as "why did you do it?" It is better to structure the interview openly by asking the client to tell you about the attempt itself, and what was happening in the days and hours just prior to it.[3] In this regard, therapists should never automatically accept the often trivial provoking issue or even a rational sounding explanation as the real cause of the attempt. Causes other than those initially mentioned are often indicated in later sessions.[4]

2. Focusing the Client

The second step of crisis therapy is that of focusing the adolescent on a problem.[5] Often the suicidal adolescent will be confused and overwhelmed by a variety of problems. He doesn't know what is wrong with him except the fact that he feels so bad he wants to kill himself! He needs help in appraising what his problems are and assigning priorities to them. It is wise to select the most important one or two problems and focus on these for the present. The rest can be explored in future therapy.

3. Evaluate risk

The therapist must carefully evaluate how likely it is that the adolescent in his office will commit suicide. When uncertain, it is wise to error on the side of caution!

Factors which will help evaluate suicide potential were discussed in Chapter 8. Some of these include age, sex, suicide plan, method, prior suicidal behavior, extent and nature of emotional disturbance, intent, and resources available to the client.

When risk is immediate, the therapist will use short, clear commands to have the client remove or destroy any method available to carry out suicide. Thus, a student with a bottle of pills might be asked to hand them to the counsellor or flush them down the toilet. In an immediate crisis, it is necessary to have the client repeat verbatim that he "will not intentionally or unintentionally do anything self-destructive while I talk to you," or, "until I see you again." A shrug or nod of the head is not acceptable. The contract can be established for an hour, a day, or even a week in less serious cases. The client who cannot make this contract is at great risk and immediate safety measures such as hospitalization may be necessary. Of course, the therapist will have to watch for the serious, psychopathic, or uncooperative adolescent who may lie and give the counsellor glib reassurances. Written contracts may be established in addition to verbal ones. Like the verbal contract, the client should promise not to kill himself for an hour to as long as a week. He should also sincerely promise that he will call you, a suicide prevention centre, or a therapist colleague if he feels he must harm himself.

Contact with a reliable and cooperative significant other in the adolescent's environment is a final way to handle immediate risk.[6] With the adolescent's permission, this person is quickly appraised of the situation, the risk involved, and given clear, basic instructions. For example, they may be told to clear the house of all medications, weapons, or other suicidal means. They should be advised to keep a constant eye on the person. This "co-therapist" should also rapidly become involved in the treatment process. The "co-therapist" is usually a parent but could be anyone close to the adolescent.

If possible, it is best to visit the co-therapist in the home to convey all this information. The home is neutral ground for such a discussion. It is a more relaxed, less fearful and less overwhelming place to convey information and instructions. Constant contact should be maintained with the co-therapist as he will need plentiful support and advice. Sometimes the family is unreliable, uncooperative, or simply unable to provide help. In such instances, the co-therapist technique is unfeasible. This is particularly unfortunate when the adolescent is a serious risk but refuses hospitalization, for a co-therapist is one way of providing safety and aid to a highly suicidal adolescent who will not enter a hospital. The co-therapist is the counsellor's right arm in such circumstances. He supplies the twenty-four hour a day care and supervision that the hospital could have provided.

4. Exploring Resources

The therapist must explore any external resources the client has available for coping with his problem.[7] These might include family, relatives, friends, neighbours, clergymen, hospitals, or another professional. Whenever possible, significant others should be involved in the therapy, though this involvement need not be as intensive as that of the co-therapist's. The counsellor may organize resources for the client such as medical attention, psychological testing, therapy, or medication.[8] It is wise to allow the client to do as much of this for himself as possible while not overburdening him.

The client should also be aided to mobilize his internal resources. This can be done by teaching problem-solving skills.[9] Some adolescents need mere encouragement to do this, while others may initially be able to only supply the information that the counsellor uses to provide aid. A problem-solving approach first asks the suicidal adolescent what realistic goals he has. Second, he decides what prevented him from achieving his goal in the past. Obstacles might include family dynamics, dependency, a wish to fail, poor self image, and so on. Third, he should consider which obstacles he can realistically change in order to reach his goals. Fourth, specific strategies are examined for overcoming obstacles. Finally, he is asked to fantasize or consider the consequences of these strategies. He might also be asked what strategies he has used in the past, whether they were effective, and if the effective ones could be reapplied. Here, the client is helped to find alternative ways of coping. He learns that he has several ways of handling the problem,of which suicide is only one option.

For many adolescents, training in problem-solving will have to start slow with small and highly structured tasks. Activity and independence demands should be increased only when the client is ready.

The client receives many benefits when he learns to mobilize inner resources through problem-solving techniques. He feels he can help himself because problem-solving is an active, independent strategy. He is not passive and dependent on the counsellor. Rigid thinking decreases and he sees alternative solutions to his problem. Thus, he does not believe he must resort to suicide as the only solution. He feels hope and worth again, for he believes he really can discover what is wrong, what to do about it, and how to implement the change. A final benefit lies in the fact that problem-solving therapy is immediate. The suicidal adolescent need not spend weeks feeling hopeless while in deep psychotherapy. Instead, he can begin recovery immediately, with small tasks. This approach should, of course, be supplemented with deeper therapy. It is simply that problem-solving skills are an excellent way of initially and continuously mobilizing the adolescent's inner resources.

5. Developing a treatment plan

A course of action is worked out between the client and counsellor. It is often specific and action orientated, and an attempt is made to involve the client in doing something for himself.[10] On the other hand, the therapist may simply refer the client to a social worker, psychiatrist, or hospital. If the client stays, crisis intervention develops into long-term psychotherapy. Long-term therapy is intended to improve his ability to communicate with others, develop satisfying object relationships, take personal responsibility for behavior, and resolve future crises with anticipatory planning.[11] The suicidal adolescent should also gain an understanding of the situation his suicide occurred in and the issues involved. Individual, group, family, and art therapy may be useful means of accomplishing these goals.

6. Evaluate the need for medication

When a suicidal adolescent appears psychotic, depressed, or highly anxious, medication may be required. Therefore, the counsellor should refer such adolescents to a family physician or psychiatrist with specialized knowledge of pharmacotherapy. Counsellors should be aware of all medications prescribed and be knowledgeable of the physical and psychological side effects of these drugs. Physicians are willing to discuss these side effects with counsellors. Also, medical texts concerning pharmacy will provide the counsellor with an exhaustive list of side effects produced by any medicine the client is taking. These side effects must be known because they influence the client's mood and reaction to therapy.

7. Termination

This is the final phase of counselling the suicidal adolescent. It must be handled with special care when the client has been suicidal for he may view termination as abandonment. In fact, even a missed appointment can be seen as rejection! As such, termination in these cases is a prolonged and careful process. For instance, therapy should not be broken off abruptly, but the time between appointments can be gradually increased. Also, it is wise to leave the door open to the adolescent for future visits. He should know he is welcome to come back from time to time.

The previous discussion has concerned intervention techniques for aiding the client in individual therapy. However, individual therapy should be augmented by a wide range of techniques. The most important of these is family therapy.

FAMILY THERAPY

Adolescent suicide is a "family affair." Effective treatment must therefore be a family matter. Suicide is also a dyadic event and family therapy must particularly try to involve this significant other if it is to be useful.

Families of suicidal adolescents often exhibit pathological dynamics. As we saw in Chapter 7, the suicidal adolescent may be the least "sick" person in the family. He merely plays the scapegoat role of "bad" or "crazy" family member. Family counsellors must therefore work with pathological relationships between all family members rather than just considering the problems between the adolescent and his parents. In short, the whole family often needs attention.

The counsellor may also have to deal with traumatic family dynamics existing years before the suicide attempt. As we saw in Chapter 7, the adolescent may have experienced previous suicide threats, attempts, or deaths of other family members. However, the present problems cannot always be traced to just the effect of prior suicidal behavior in the family and its repercussions. Divorce, mental illness, depression, hostility, and ambivalence are also motivators.[12]

The families of suicides which result from environmental stress, respond more favorably to treatment than families where suicide is linked to extreme family and adolescent psychopathology.[13] These latter families are harder to change because they have developed longstanding patterns of family dynamics to fit the adolescent's unusual needs. Thus, families have a better prognosis when suicide is related to sudden, acute, and temporary stress.

The younger the adolescent, the more necessary it is to involve the family in therapy.[14] However, it is wise to involve the families of even older adolescents wherever possible. Regardless of the adolescent's age, counsellors should continue individual appointments with the client in addition to the family sessions he participates in. There are often things the adolescent wishes to communicate to the counsellor privately, apart from family sessions.

Involving the family in therapy will not be easy. Counsellors can expect denial, resistance, and hostility toward attempts to involve the family, and even the adolescent himself, in treatment.[15] Resistance may be subtle, such as not showing for appointments. Other resistance may be blatant, and take the form of angry refusals and complete denial that the adolescent (or the family) has a problem. The counsellor may be told he is wrong and the adolescent just had an "accident." Men in particular refuse therapy contacts - not only for themselves, but on behalf of the whole family![16] Often the men will say they are trying to protect the adolescent and the family because it "would be too much for them to handle at this time."[17] Children who need help the most are routinely kept from therapy.[18] Men may refuse therapy on behalf of the family even when other family members have already indicated their willingness to make the therapy contact.[19] This is an unfortunate state of affairs for it is often the father who is most upset by the adolescent's suicidal behavior.[20]

How can a counsellor overcome such resistance? Two suggestions may help. First, visit the family immediately after the attempt. While parents resist intervention weeks after the suicidal event, they are frequently highly motivated to seek help, and desperately willing to talk, in the first days after the act.[21] In their initial panic and grief, they also reveal feelings and information which might otherwise elude the therapist. Even brief contacts in these early days can establish enough rapport to pursuade parents to enter family therapy. Ideally, the therapist should try to contact the family within twenty-four hours of the suicidal incident. Otherwise relief, denial and complacency close the door to communication when the adolescent begins to recover. Second, therapy should be conducted in the family's home whenever possible. This is a "safe," relaxed, and neutral place for them to meet with you and they may be more cooperative as a result. If they are forced to visit a professional in his office, they may feel intimidated and overwhelmed.

The key job of the counsellor is that of opening verbal communication channels between the therapist and the client, and later between the parents and the client.[22] Communication between all other family members will also have to be developed. The counsellor hopes to improve verbal communication to the extent that future conflicts may be expressed in words rather than desperate action.

During therapy the dependent suicidal adolescent often begins to exhibit independence strivings. He may also exhibit other healthy changes. However, others in the symbiotic family will often interpret any changes as signs of disturbance.[23] They will also feel highly anxious because changes in the adolescent often necessitate changes in family dynamics. This may prompt the significant others to act with excessive protectiveness in an effort to smother any change.[24] Threats,such as rehospitalization, may also be made against the adolescent as he begins to get better.[25] The family may even attempt to sabotage therapy. As the adolescent recovers, the therapist will have to be watchful for all such family manouvers. Attitudes and behaviors destructive to therapy should be diplomatically uncovered, explored, and modified. Feelings of anger, hostility, helplessness and ambivalence will have to be aired and handled. A firm emphasis on reality testing will be needed and the counsellor will have to break through layers of myths and "unreal" ways of thinking.

In initial family therapy, the counsellor does not delve too deeply. His role is mainly a supportive one. Nevertheless, he is building rapport, watching, listening, and gathering information for use in future sessions. As time goes on, he will wish to uncover deeper family conflicts.

The therapist will also attempt to therapeutically modify the family environment. Such modifications should be discussed, planned and implemented by the family with the counsellor's knowledge and support. Environmental manipulation of the family situation is an important part of the counsellor's job because the adolescent attempted suicide to change an intolerable situation. The counsellor must discover what this situation is and then set out to aid this change.

In addition to working with communication skills and the environment, the counsellor will have to help the family define the suicidal adolescent's rights. For instance, he doesn't have to have his mail screened, or consult the family on every decision, for he is not an infant or a "raving lunatic!" The counsellor should also clarify what the family can expect of the suicidal adolescent. The family needs to know what can be expected from a depressed person and what can push him too far. Sometimes a family will pressure the adolescent to resume his former routine in the belief that he will get better if he keeps busy. While this is appropriate in some cases, other suicidal adolescents are overburdened by such demands.

In extremely uncooperative family situations, the therapist may decide to place the adolescent in hospital merely to give him a temporary break from the suicidogenic family environment. If the home is bad and there is no hope of change, the adolescent may even be permanently removed from the home.[26] Some alternatives to hospital are placement with relatives, foster parents, or a group home. These alternatives are certainly last resorts as improvement through family therapy is the ideal solution. The counsellor also has other techniques for helping suicidal adolescents. One of these is environmental manipulation.

ENVIRONMENTAL MANIPULATION AND FOLLOW-UP CARE

Suicidal adolescents are frequently discharged from hospital with no changes made in the suicidogenic environment to which they are returning. Often there are no arrangements made for follow-up care other than vague advice to parents to seek psychiatric help for their child.[27] It is vitally important that contact be maintained for at least two years after the attempt.[28] The contact need not always be intensive, but it should be maintained so the adolescent has confidence in the therapist and is willing to get in touch with him if he needs him.

Schools should be closely involved in follow-up care with suicidal adolescents. Counsellors and school psychologists should be in immediate contact with any suicidal adolescent who is returning to school from hospital. As mentioned, this contact should continue for some time. If this is done, one need not depend on parents who often do not seek psychiatric help for adolescents. The school is the ideal place for follow-up care.

Unfortunately, schools are reluctant to deal with the problem of adolescent suicide or even admit that it exists.[29] Jerry Jacobs, an expert on adolescent suicide, states,

> If these people were to recognize a potential suicide, they would hasten to refer him to a doctor, a psychiatrist, a psychologist, a social worker - in fact, to any likely candidate outside the school system. This leads one to wonder: What do these unlucky experts do?[30]

We might also ask what these unlucky "experts" do that our own school counsellors and psychologists should not be doing. What are they being trained for if it is not to handle student problems such as this? Unfortunately, suicidal adolescents realize such topics are taboo in the school. They know they will not find help in the school system - the most they can expect is a panic referral. Had they wanted this, they would not have come to their school counsellor! The suicidal student can expect school personnel to "wash their hands" of him, fast! It is time school therapists were trained and prepared to deal with the problem of suicide.

In addition to providing follow-up suicide care, school therapists should plan and organize beneficial environmental manipulations in the school. This may involve helping the student change schools, modifying his course program, finding tutoring services, providing psychological testing, doing career planning, involving special academic consultants, instituting remedial programs, and resocializing the student with his peers. Teachers might be asked to give assistance. Also, regular interdisciplinary conferences should be held during the follow-up period. Conferences would involve school therapists, teachers, family, and administrators. Such conferences would keep watch over the adolescent's progress. It is vital that all school personnel work together, for the care of the suicidal adolescent is too great a responsibility for the school therapist to handle alone.

Not all follow-up care need occur in schools, though schools are one of the best situations. In Hungary suicidal adolescents are given medical attention and then referred to advisory centers which are allied to a system of social clubs.[31] These clubs try to get the lonely suicidal adolescent resocialized. Anyone can join and the clubs provide help to the elderly in the community. There have been no outbreaks of suicide epidemics among club members.[32] It would be an exciting happening if our schools instituted "helping" clubs which troubled adolescents could join (in addition to other students). The clubs could provide aid to the community and social occasions for troubled adolescents to attend. Perhaps these clubs could be affiliated with volunteer action centres. However, they should remain based in the schools where they can reach the adolescents who need them most. Lonely and troubled adolescents need others. "Clubs" are one answer. Schools should also provide group therapy.

GROUP THERAPY

High schools should get groups of adolescents together with similar problems. Troubled adolescents are lonely and isolated in our impersonal schools. Loneliness is overwhelming when one has problems. Groups can give troubled adolescents the chance to communicate and make contact with other human beings. Adolescents may also be more willing to air their thoughts and feelings with other adolescents as they often see teachers, counsellors, or school psychologists as authority figures. Group therapy solves this problem because each member serves as a mirror for others and all members are equals. The possibility of acting-out behavior is lessened because there is less emphasis on an authority figure than there would be in a client-counsellor relationship.[33] The strain of such a group is often too much for one counsellor to handle. Of course, not all the adolescents in the group need to be suicidal. Adolescents with similar problems, but no history of suicidal feelings, should be included to get a good "mix." In fact, suicide is not discussed in the group as much as the problems and goals the group members share.[35]

The group helps the adolescent plan constructive action. The focus is on immediate problems they share and the solutions they seek. The deeper dynamics of the group may be seen by the leader but are seldom presented to the group for confirmation or insight. The preferred emphasis of a school therapy group is on support, friendship, and developing active problem-solving skills for present problems. Deep insight, confrontation, and other techniques are best left for non-school groups.

In addition to providing companionship, and a chance to verbalize feelings rather than act them out, groups provide other benefits. Groups can reduce the suicidal adolescent's dependence on the therapist. This is beneficial for the client and a relief for the therapist over-burdened with responsibility. The suicidal adolescent also bolsters his shaky ego by helping others. He learns communication skills, is resocialized, and sees that others in the group care for him.

Group therapy is not meant to replace individual suicide therapy. It is simply one of many techniques which should be combined with individual therapy to produce optimal treatment. A further intervention therapists may use is that of pharmacotherapy.

PHARMACOTHERAPY

Psychopharmaca are used when adolescent suicide is accompanied by depression, agitation, or tension.[36] Such treatments are effective, but therapists must be aware of their drawbacks. For instance, barbituates, like phenobarbital, can produce or intensify a depression.[37] Thus, doctors must be careful who they prescribe such drugs for. This is highlighted by the fact that many suicidal adolescents visit physicians before their attempt with various somatic complaints.[38] Before a doctor prescribes medication for undiagnosed somatic complaints, he should be alert for signs of depression and suicide. These signs would contraindicate certain medications.

Medication and electroshock therapy may not be as helpful with adolescent suicide as they are with adult cases.[39] Adolescents do not seem to respond as well to these techniques as adults. Perhaps this is because suicidal adolescents do not exhibit depression, or the same kind of depression that adults do. Meanwhile, psychiatrists may be assuming that all suicidal adolescents are depressed, treating them as such with antidepressants and electroshock, and then wondering why they do not recover. It is time we asked which medications are best for different kinds of suicide. There are depressed suicides, agitated suicides, rational suicides, irrational suicides, nondepressed suicides, etc.

Some suggest that the use of electroshock with suicidal adolescents may impair the chances of establishing a good therapist-client relationship.[40] As such, medication and electroshock are not the whole answer to treating adolescent suicide. They are never an alternative to psychotherapy and other techniques. They will likely not be successful unless combined with a comprehensive program of psychotherapy.

When combined with psychotherapy, medication may aid the insight process. It can "buy time" for psychotherapy to produce results. Medication can also blunt the suicidal urge, alleviate some depression, stop psychotic delusions, soften overwhelming emotions, and rationalize thinking. All these, if not checked, would certainly hinder the client's ability to benefit from psychotherapy.

We have seen that pharmacotherapy and psychotherapy are two complementary techniques. The psychotherapist has a large array of weapons he can use in his fight against adolescent suicide. These include crisis intervention, individual psychotherapy, group therapy, follow-up programs, social "clubs," family therapy, environmental manipulation, and pharmacotherapy. Research indicates that past and present intervention in suicide has not been very effective.[41] This is likely due to the fact that therapists often opt for one technique or another. A counsellor may see the client individually but never bring in the family. School counsellors are seeing clients alone but not taking advantage of group counselling "club" approaches and follow-up programs. The effective solution involves combining as many of these complementary interventions as possible. The counsellor needs to mobilize all the techniques, people, and resources he can find if he wants to provide effective aid for the adolescent who suddenly walks into his office and announces, "I'm going to kill myself!"

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CHAPTER 11

TREATING THE SURVIVOR-VICTIMS OF SUICIDE

When a person exhibits suicidal behavior, all attention is focused on him. In our preoccupation with the "star" of the event, we often forget the parents, children, relatives, and friends who are left without the support of community or friends. These survivors are seldom reached by psychologists or other professionals. They are alone in their grief and left with a profoundly disturbing legacy. Even when their adjustment to the death seems normal, the bizarreness and malignancy of their projective test responses attest to the fact that the adjustment is usually superficial.[1] There is often trouble ahead for the survivor-victims of suicide.

If this were not unfortunate enough, survivors usually retreat from overtures of help.[2] This inaccessibility may be due to guilt and denial. Also, an offer of help may imply family blame for the suicide, or mental illness in the family.

There are several ways of overcoming resistance. First, the family should be contacted within twenty-four hours of the death, and certainly before the funeral.[3]

While they are in shock they are often more receptive to help. A wait of even one week may make it impossible to reach the family.[4] It is necessary to establish contact before defensive reactions can form. Second, the family should be seen in the relaxed setting of the home.[5] Also, supervised volunteers who are themselves survivors of suicide should visit the family. The volunteer is not associated in any way with persons investigating the suicide. Thus, they are met with less hostility. An example of such a program is Boston's widow to widow service.

If families, relatives, and friends can be reached, they often report that they are grateful for the therapy contact.[6] They particularly want someone to talk to in the first days following the attempt or death.[7]

A person's reaction to the suicide of a relative or friend is determined by several factors. One must consider his past experiences and relationship with the suicidal person. The circumstances surrounding the act also determine survivor reactions. Finally, a child's reaction to parental suicide will be determined by the child's personality prior to the attempt, the surviving parent's personality, the nature of the child's involvement in the suicide (if any), and the child's age.[8]

Often the context in which the suicide occurs is not healthy. As we saw in Chapter 7, ambivalence, hostility, and psychopathology exist in many families before the act occurs. After the suicide, family members are so griefstricken they cannot be of help to one another. There may be needs to externalize blame to one another.[9] They will have to deal with new problems erupting in each other and the need to restructure their family and social roles. There will be wishes to replace previous sources of need gratification. Finally, the social milieu usually surrounds survivors in a net of stigma, shame and hidden communication of blame.[10]

SURVIVOR DEFENCES

Survivors use many defenses to deal with the shock, guilt and overwhelming feelings engendered by the suicide. A key defense is often denial, and it acts as a primary defense against feelings of rage, abandonment, and desertion.[11] Denial can take many forms. Some will doubt the suicide ever happened. It may be called an accident, a heart attack, etc. Others deny the significance of the suicidal person by characterizing him as weak, cruel, bad, or inadequate. Some idealize the suicidal person and believe he acted heroically in the circumstances.[12] Unfortunately, denial is a vulnerable defense because its blantentness is readily assaulted by reality forces. Thus, survivors may turn to other defenses.

Reaction formation is a defense that represses disappointment in the deceased.[13] Disappointment is replaced by expressions of unambivalent love or idealized rememberances. If reaction formation fails, guilt will increase and turn against the self. Excessive mourning, masochism, and penitence may then alleviate this guilt. Withdrawal is also a defense that some survivors use to combat guilt.[14] Samuel Wallace found that seven of the twelve widows he studied began coping with a spouse's death by using withdrawal.[15]

Other survivors find relief through a flight into activity.[16] This may be an attempt to demonstrate that the attempt or death had no effect on them. One group of eighteen-year-old boys reacted to the suicide of a friend by a frantic round of parties and meetings to play soccer or football. One concerned mother remarked, "If those boys don't slow down, they'll fall down!" Other survivors rapidly transfer dependence feelings to a new spouse, friend, boyfriend or girlfriend. Finally, there are those who rationalize the act by blaming it on external forces such as school or work pressure. In this way they can alleviate self-blame.

As can be seen, survivor reactions provoke numerous defenses. The reactions that give rise to such defenses will now be examined.

SURVIVOR-VICTIM REACTIONS TO SUICIDE AND SUICIDE ATTEMPTS

1. Guilt

Guilt is a standard reaction to the suicide death or attempt of a significant other.[17] Parental guilt may stem from beliefs that if one had been a better parent, the adolescent wouldn't have resorted to suicide. A surviving friend or child may also feel guilt. There is often a belief that one's badness and ineptitude led the parent or friend to resort to suicide. Some feel they could have prevented the act had they been home, more observant, etc.

Sometimes an adolescent will feel that the suicide was prompted by his strivings for independence from the parent, or wishes to end a love relationship with a suicidal boyfriend or girlfriend. This is especially true if the relationship was a dependent one prior to the suicidal behavior. Clients may continue to feel guilt at achievement and independence strivings long after the suicide.[18] A final source of guilt may be the anger the adolescent feels toward the suicidal parent, friend or love object. He is angry at being abandoned and this makes him feel more guilty.

Guilt can be a defense against feeling helplessness about the significant other's death.[19] Some clients need to feel guilty about the death because the only other alternative to feeling responsibile is helpless and frustrated rage. Such emotions may be harder to handle than a sense of guilt.

Guilt is displayed in many ways, including masochistic character formation, depression, death fantasies, and self-destructiveness.[20] Reaction formations of passivity, ultragoodness, and rebellion against an externalized superego are common.[21] Excessive goodness can be shown by over-compensation, being very achievement-orientated, and doing excessive work to get high marks in high school.

Guilt can come from many normal sources. It is natural for a boy to feel anger at his father for not buying him a new bicycle. He may then feel guilt after the father's suicide. However, there are special sources of guilt in a suicidal relationship. As we saw in Chapter 7, the dynamics of the suicidal family involve manipulation, ambivalence, hostility, unconscious death wishes, and dependence. This causes excessive and unnatural guilt, for when suicide occurs in such a relationship, the survivors feel relief and satisfaction. Excessive guilt grows from the unusual preexisting dynamics of the suicidal relationship. When suicide occurs in this context, it particularly difficult for survivors.

2. Disturbed Self-Concepts[22]

The survivor's poor self-concept results from shame, social stigma, and dishonor. Feelings of being cast away, or abandoned by a parent or love object,also contribute. The survivor-victim becomes unsure of himself and others.

3. Impotent Rage[23]

Rage is intense in survivors but it is often hidden. Rage is increased by feelings of desertion and having ongoing needs of security and love frustrated. The spoken words are, "Why did he do it?" The unspoken sentiment is, "Why did he do this to me?"

4. Reality Distortions[24]

Distortions include denial, repression, evasion, concealment, anxiety-clouded memories, and redefinitions of the event which is parlayed into family or gang myths. Families and friends seldom speak of the suicide.[25] The demand to not communicate is so subtle that many report they knew,without being told,to never speak of it.[26] The distortions are so great that children who witness the suicide may be told within hours of the event that they were mistaken - the death was not suicide, but an illness or accident! For example, a boy who watched his father kill himself with a gun was told his father had a heart attack.[27] Other distortions occur when family, relatives, and friends give different versions of the suicide death.[28]

When children question these versions of reality, they are often shamed, derogated, or told they must have confused it with a dream. The child learns that "knowing" or "speaking" are forbidden; shyness, reluctance to speak, stammers, and learning disabilities can result.[29] Other results include feelings of unreality, weakened reality testing ability, ego splitting, and a lack of commitment to reality.[30] Survivors can expect little support from one another for the whole subject is taboo. Consequently, the person has no chance for catharsis, relieving guilt, or having reality corrections placed on fantasies surrounding the death. There may also be a distrust of the reality of their experiences and a pervasive uneasiness about most of the things we accept as life's certainties.

5. Tortured Object Relationships[31]

Survivor-victims suffer from loneliness, a hunger for closeness while fearing closeness, and a disillusioned distrust of human relationships. They may also need to reenact separations by driving love objects away, or cling to love objects at any cost. Thus, the original ambivalent and symbiotic family dynamics are perpetuated in future relationships. The child may particularly cling to the remaining parent.[32]

6. Identification with the Suicide[33]

Children and adolescents often identify with the suicide as a result of archaic introjection mechanisms, and interpersonal family forces that pull towards a redefinition of the self and one's family role.[34] The "sick" member of the family is gone and they often begin to watch the adolescent in case he becomes "crazy" like the dead parent or sibling.

Another reason exists for the identification. Consider an adolescent growing up with a depressed parent who has made frequent suicide threats. He comes to believe that death is reversible and not real. It is merely something powerful that one does to achieve a desired result - and he has felt the power of suicide threats and attempts!

Identification can take other forms. Some believe they will die by suicide like their parent or friend. It is easy to see similarities between the self and the dead parent, for family members reinforce such similarities. Others begin to fear their own suicidal impulses.[35] They fear that if a parent or friend can do it, anyone can!

7. Depression and Self-destructiveness[36]

These result from shame and unresolved guilt. Signs include active self-hatred, emptiness, apathy, withdrawal, sadness, despair, and total immobilization. The depression is exacerbated by the identification process noted in the previous section.[37] Other indicators include self-destructive lifestyles, suicide fantasies, suicidal preoccupations, repeated suicide attempts, and completed suicides.[38]

8. A Search for Meaning[39]

Survivors constantly go over the suicide in their mind as they seek the reason for a seemingly senseless event. Some try to avoid the search through suppression, keeping extremely busy, or exerting rigid and abrupt foreclosure on all but one standard interpretation of the event. The question "Why?" must be answered. Unfortunately, most answers include guilt and self-blame.

9. Acting-out Behaviors[40]

While some surviving adolescents exhibit sadness and depression, others act-out. They appear angry, aggressive, truculent, and defiant.

10. Incomplete Mourning[41]

Denial, concealment, shame, guilt, and avoidance of communication make mourning a difficult process for survivors. The withdrawal of friends, family, and relatives results in a lack of opportunity for sharing grief, reassurance, support, or reality-testing. Thus, the mourning process is hindered, and survivors often become "stuck" in their grief.

As can be seen, survivor-victims are a terribly burdened group of people, and as worthy of intervention as the suicidal person himself. Many are in desperate need of someone to listen to the overwhelming emotions they suffer. Every effort should be made to get help to survivor-victims; otherwise, today's child-victim may become tomorrow's adolescent suicide with "victims" of his own. The rest of this chapter will deal with ways of helping survivor-victims.

GENERAL PRINCIPLES UNDERLYING SURVIVOR-VICTIM THERAPY

There are five principles governing survivor-victim therapy. The first of these concerns the fact that survivors must accept the suicide in their own time. However, they must eventually accept the attempt or death as suicidal in nature.[42] Speculations that the act was an accident,or other refusals to face the truth,merely circumvent the normal grieving process.

Second, the family must be convinced of the value of crisis intervention.[43] This is not easily done, for families of suicidal adolescents find it very hard to share their grief. Fathers are most difficult to reach and often only one family member will accept help.[44] Family members may also withdraw from one another. There is self-blame and blame of others, so help is denied and rejected.

Third, survivor-victims need to learn that grief is self-limitimg.[45] Family and friends should be reassured and encouraged to work through their grief. They should be told that if they acknowledge the grief and work it through, the pain will subside. The process, if allowed to happen, will resolve itself - life will return to normal! Signs of inability to grieve include lack of conscious sadness, denial of the significance of the loss, no conscious longing for the deceased, inability to cry, avoidance of new object relationships, and fantasy maintenance of emotional bonds with the deceased.[46]

Fourth, family members must learn how children and adolescents mourn.[47] Also, friends must learn how other friends grieve and handle depression. Signs include anger, sadness, regressive behavior such as temper tantrums, and sudden inability to get along in school.

Fifth, survivor therapy begins slowly with support and reassurance.[48] At first it may be enough to listen and express sympathy. If therapy is short-term, it will focus on such support,with realistic acceptance of the death, and relief of guilt feelings. Only in later therapy is the expression of rage encouraged and the deeper effects of the suicide explored.[49] In particular, deeper therapy may uncover pathological family dynamics and communication patterns. These should be discussed, and family members should be aided in their attempts to change communication patterns and family dynamics. In general, survivor therapy can be divided into three phases. These phases will be discussed in the following section.

PHASES OF SURVIVOR-VICTIM THERAPY

The first phase of survivor-victim therapy is psychological resuscitation. It should begin within twenty-four hours of the attempt,or death.[50] This phase provides psychological first-aid to survivor-victims. The counsellor establishes rapport, guides survivors through shock, and helps them become aware of their initial reactions such as guilt, blame, confusion, hostility, and depression.[51] However, these realizations should not be forced, and initial defenses should be allowed at this stage.

The second phase is that of psychological rehabilitation.[52] It takes place in the six month period following the suicide.[53] The aim is to make contact with family members, either alone or in a group. Regular meeting times are established. Meetings may take place in the home, the therapist's office, or a combination of both. Goals are: support, reintegration of the remaining family, and aiding family members to grieve and understand the mourning process.[54] The therapist will also have to deal with any emotional or social crises that arise at this time. Meetings may be held as often as two to three times the first week, weekly for the next three to four weeks, and less frequently for the remainder of the six-month period.[55]

The final phase is that of psychologic renewal; it begins about six months after the suicide.[56] At this time, the family is usually regaining its integrity and needs fewer visits.[57] However, there are still sources of family anxiety during this final phase. Stressful times include anniversaries of the beginning of therapy, past attempts, and past suicides.[58] Birthdays and holiday seasons are also difficult times.[59]

It is useful to reevaluate any continuing problems after the first anniversary of the suicide death.[60] The family may not need further therapy, or one family member may need referral for longer-term counselling.

FUTURE DIRECTIONS FOR SURVIVOR-VICTIM THERAPY

Survivor-victim therapy is still in its infancy. Community outreach programs such as Boston's widow to widow service must be developed. Currently, most survivor-victims receive no aid at all! This situation must be rectified for survivors of suicide have been neglected too long. Society pays for this neglect in future suicides, psychopathology, and needless misery.

We also need to begin group therapy for survivors and organize associations for them. Group therapy need not uncover deep psychodynamics. Instead, the emphasis should be on support. Survivor associations might resemble Alateen or Al-Anon groups where "victims" of alcoholic families gather to receive support and education concerning alcoholism.

Above all, we need to know how nonpathological survivor-victims of suicide have managed to cope with suicide. Most of the current studies in this area involve deeply troubled persons who have sought therapy.[61] We know something about pathological coping patterns but little about successful methods which might help others cope. Only further research can supply these answers.

SURVIVOR-VICTIMS IN THE SCHOOL

A final comment concerns survivor-victim therapy in the schools. Throughout this chapter, family victims have been discussed, but little has been said about other survivor-victims of suicide. Pathological reactions to suicide are not confined to the family. Employers, physicians, love objects and therapists do not escape the legacy of suicide. Students constitute one of the largest groups of unrecognized survivor-victims.

Schools don't see themselves involved in survivor-victim problems, but many students have lost parents and siblings through suicide. They need help in dealing with their burden and this help should be given by school therapists. Also, students themselves are attempting and committing suicide in increasing numbers. Each of these students has a circle of friends who are devastated by the suicide. Let us consider an example. One eighteen-year-old male made a near-lethal suicide attempt. His life hung in the balance for two weeks. His close friends were about to write grade twelve exams, but were so upset they could not sit for the exams. All experienced severe guilt, insomnia, and noticeable depression. The effects lasted for months, and all report that after several years, they are still "shook up" when they think about this incident. They were honor role students and star athletes, but their grades fell along with their participation in school sports. Sadly enough, school counsellors and staff were unaware of the suicide attempt, and did not offer support to the suicide's friends.

School therapists and administrators should be aware of any student's unexplained absence from school, or any student's hospitalization. They must be cognizant of the suicide problem in their midst and the devastating effect it has on other students. Personal experience,from talking to students,indicates that reactions are currently hidden from school staff who seldom know a student committed suicide. Strangely enough, the students in the school are immediately aware. It is time we tuned in to this "grapevine."

Although immediate friends of the suicidal adolescent will be deeply affected, other students do not go unscathed. Even students who scarcely knew the suicidal adolescent are hit by a hidden ripple of anxiety and sadness. The shock spreads over a whole school and leaves such a deep impression that university students can often recall,in detail,the events surrounding the suicide of an unknown student during their high school days.

Thus, school therapists must become aware of the suicides occurring in their midst. They should then make an effort to seek out the suicidal adolescent's surviving friends. This should be done almost immediately. Support must be given to these neglected survivor-victims and active outreach programs are needed in our schools to contact and aid these adolescents. Until then, suicide will continue to carve its mark on our schools. What a terrible legacy for one suicidal adolescent to leave!

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CHAPTER 12

THE PREVENTION OF SUICIDE

Current efforts to predict and intervene in suicide do not seem effective. New psychotrophic drugs and hospitalization have not affected the suicide rate.[1] There is also no evidence that suicide prevention centers,which specialize in telephone referrals,have reduced suicide in the areas where they are located.[2] Despite all these efforts, suicide is increasing at a rapid pace.[3] As we have seen in the last three chapters, programs have little impact because they are infrequent and poorly implemented.

There is also a more fundamental problem with our current attempts to prevent suicide. Most of our efforts try to stop suicide when it is too late. We wait to intervene until problems are so desperate that persons have considered killing themselves. This is similar to not calling the fire department until the fire has spread through the whole house! When the firemen arrive they work valiantly, but there is little they can do. Firemen realize that once a fire occurs, they can only hope to prevent it from spreading to other buildings. Consequently, fire departments have learned the value of preventing fire - houses are inspected, wiring is improved, and safety features are common on electrical appliances.

Like firemen, those who fight suicide can try to cope with the suicide crisis once it flares up. However, prevention is the ultimate and only way to significantly decrease suicide rates. This does not imply that efforts to predict and ameliorate suicide crises should be disbanded. The argument is merely that current programs must be supplemented by preventative efforts if we wish to make headway in the fight against suicide.

In order for prevention programs to work, they must be varied and broad in scope. As we have seen, community, family, and schools all contribute to adolescent suicide. Therefore, prevention efforts must be equally broad in scope. The rest of this chapter will be devoted to a discussion of the suicide prevention techniques which can decrease suicide rates.

We have seen that prompt intervention with survivors of suicide may prevent future suicides,for survivors are a high risk group. The prevention efforts discussed in this chapter will concern the community, the school, and the need for more research on adolescent suicide. Let us first take a look at preexisting programs,such as suicide prevention centers.

SUICIDE PREVENTION CENTERS

There are currently 95 suicide prevention centers in Canada and about 120 in the United States.[4] Most services operate a twenty-four hour telephone crisis service which is staffed by volunteers.

These centers assume that most people are ambivalent in their wish to kill themselves. When a suicidal person calls, a volunteer tries to tip the balance of the suicide urge in favor of life. Actually, the term Suicide "Prevention" Center is a misnomer for these centers do not prevent suicide in the real sense of the word. They generally intervene in the midst of the suicide crisis. Treatment is usually short-term crisis intervention with referrals for those who need long-term help.

The typical caller to a prevention center is a 25 to 35 year-old female.[5] Her suicidal feelings are not acute; she is unhappy, but generally well integrated.[6] She is not addicted to alcohol but a significant other in her environment often is.[7] Frequently the caller is a middle class wage earner who tends to focus on one superficial problem, rather than looking at the underlying issues.[8] There is little history of having sought previous psychotherapy and the caller has usually made no previous suicide attempts.[9] In conclusion, the typical caller to a prevention center is low risk. Those at highest risk seldom call the centers.[10] Suicidal adolescents also rarely contact prevention services.[11]

Thus, callers are a very select and low risk group. We are not reaching adolescents and high risk suicides. Nevertheless, the centers have value because mildly suicidal persons are certainly at risk when compared to the general population. They deserve help, or their next attempt may be lethal. In summary, centers may insure fewer and less lethal future attempts.

Suicide prevention centers are most effective with low risk and acutely suicidal persons. They have less success with high risk and chronic suicides. This is due to the fact that suicide centers specialize in short-term crisis intervention. This kind of help is most effective with those who have previously been stable,but have fallen into disequilibrium due to some acute stress in their lives.[12]

While crisis intervention works with callers who have stable backgrounds, more than sixty percent of callers do not fit this requirement.[13] Even those who appear stable report that they are seeking supportive, consultive, and problem-solving sorts of advice, rather than crisis intervention.[14] We may conclude that crisis intervention, which centers consider their major job, is seldom what clients wish or need. Also, those who need help most are not calling the centers - and those who call, are not getting the kind of help they wish. Suicide prevention centers can institute several changes to correct this situation. Follow-up and outreach programs are two badly needed innovations.

FOLLOW-UP AND OUTREACH PROGRAMS

Currently, suicide prevention centers provide short-term crisis intervention. This may only postpone the suicide, rather than prevent it. Also, these centers seem to be particularly ineffective in combatting adolescent suicide. Clearly, we can not wait for high risk suicides and adolescents to call us - they have shown that they will not call. Also, we need to provide long-term contact and follow-up for chronic suicides, because they need rehabilitation rather than crisis intervention.

There are many ways to reach adolescent, high risk, or chronically suicidal persons. First, callers should not be abandoned after short-term intervention. Suicide centers must change their emphasis on telephone counselling in favor of home visits, group meetings, individual counselling, and friendly telephone calls. This would insure that suicidal persons are supported by a wider array of services, over a long period of time.

These centers must also reach into the community and contact those who will not come to them. It is precisely these persons who need help the most. There are ways to initiate community contacts. Certainly, prevention centers should work in close liaison with senior citizen homes, alcohol and drug rehabilitation centers, and city shelters. Prevention teams could also be affiliated with churches, synagogues, community centers, teen drop-in centers, and high schools. If necessary, workers could even begin door-to-door canvassing of anomic city districts to establish a link between the center and the people of these areas.[15]

Centers should begin follow-up programs for suicidal adults and adolescents who have just been released from hospital. Contact should likewise be made with those who have records of previous attempts. This would entail hospitals keeping better records of suicidal persons, and prevention centers working in closer affiliation with hospitals, physicians, psychiatrists, and psychologists.

An interesting innovation in prevention services is that of "befriending." Here, a volunteer visits a suicidal person on a regular basis and establishes a helping relationship with him. One example of this is the Samaritan movement in England. The effectiveness of befriending is shown by the fact that suicide rates decrease wherever such groups exist.[16] As such, befriending is one of the most effective techniques we have for combatting suicide. An exciting variation of this might be adolescent volunteers who befriend suicidal adolescents. Certainly, adolescents are aware of the suicide problem in their schools and wish to help in some way. As one student stated in a discussion with the author, Student: You know, he was a really nice guy - we were really shocked when we saw them carry him out of the house to the ambulance. I wish there was something we could have done - I mean... We didn't know how bad he was feeling or we would have talked to him more - spent some time with him, and now...now it's too late! I just wish if there were others like him, we could know and do something - not just sit here while someone next door to you dies! You know, he needed more friends - like he was kind of lonely. I bet having friends would have made it different for him.

Author: You know, there are volunteer organizations that visit suicidal people. They are called samaritans.

Student: Why isn't there something like that here? You know, I'd like to join something like that! Boy, do we ever need it in this school!

While befriending is a useful technique,and one that ought to include adolescents, it is not the whole solution. Some suicidal persons do not respond to befriending. Those with severely inadequate personalities may be uneffected, and those with aggressive psychopathic traits could possibly be harmed.[17] Such persons are so unresponsive,or aggressive,that befriending cannot integrate them back into society. Suicidal adolescents may respond to befriending in better fashion, for as we saw in Chapter 6, they seldom exhibit these extremes of pathology. In fact, their acts are often aimed at establishing contact with others. Befriending is an ideal way to answer this appeal. However, one further danger exists in the technique of befriending. Occasionally, relationships with unrealistic expectations and high dependency are formed.[18] When such relationships end, or hit a snag, the suicidal person feels abandoned and despondent. Consequently, befrienders must be trained to recognize who should be befriended and who should not. They should also be carefully supervised by trained specialists who can help them make these decisions. Unacceptable clients can then be referred to other forms of preventative services.

To this point, we have been discussing prevention services connected with suicidal centers. This does not imply that the center should directly handle all the suicidal problems in an area. Rather than this, centers should mobilize community efforts against suicide. The following section will discuss suicide prevention based in the community.

SUICIDE PREVENTION IN THE COMMUNITY

While suicide prevention centers work directly with some cases of suicide, their major job should be that of helping the community handle its own suicide problems. The center should mobilize, educate, and coordinate the community's efforts against suicide. Persons involved in medical, legal, educational, and social welfare activities could then phone the center for assistance when working with suicidal clients. In some instances, the center may merely provide information concerning community resources, available clinics, methods of hospitalization, committment procedures, etc. At other times, trained professionals should provide consultative advice, workshops on suicide, etc.

Above all, centers must help the community plan a wide array of preventative services. For instance, therapeutic social clubs should be set up and associations must be formed for suicidal persons and survivor-victims. Some of these clubs and organizations should be specifically for adolescents. We also need psychiatric social workers and other professionals who are highly trained in the field of suicide. They would become directly involved with suicide in the community and work with the suicidal person, his family, and friends. Above all, we need to establish halfway houses for suicidal persons who have just been discharged from hospital. This is especially needed for the adolescent whose family situation is pathogenic. Currently we have few options other than to send the adolescent back home. Halfway houses would provide an alternative.

Training programs are needed to teach persons in the helping professions to recognize and work with suicidal persons. For instance, nurses and physicians should be more sensitive to the problem as 65 percent of suicidal persons visit a physician shortly before committing suicide.[19] Clearly, physicians are not recognizing and helping these persons. Educative efforts may correct the attitude that doctors treat physical ills but have no business becoming involved in a person's decision to kill himself. Doctors feel they have no right to interfere.

Hopefully, physicians will change their orientation towards psychiatric referrals in these instances. When this happens, hospitals may stop treating the suicide's injuries and immediately releasing him from hospital with vague instructions to "get some help."

The police force should also be given suicide training. They should know how to deal with the suicidal person as well as panicky and hostile family members. They must also help the family realize the suicidal person needs to be referred for help. Such a program is operating successfully in Berkeley, California, and should serve as a model for all Canadian police forces.[20]

Doctors, nurses, police, school administrators, teachers, and school therapists must all be able to recognize the signs of suicide. To do this, they need to be well acquainted with psychiatric problems, the subtle signs of psychopathology, and the clues of borderline psychoses. School staff, and even counsellors, seldom recognize troubled suicidal students.[21] Perhaps this is the reason they are surprised when a "model" student commits suicide. They have likely missed many distress signals from the student.

Professionals should also be skilled in crisis intervention techniques. Once they recognize a troubled adolescent, they need to be able to provide help immediately. Referring the student for help, which may not arrive for days, is not timely enough to prevent suicide. Often, a school nurse or teacher cannot wait until the school psychologist arrives the next day. The school psychologist cannot wait until a psychiatrist will see the student. The student needs to talk to someone right at that moment! It is not too idealistic to expect highly trained professionals to have the same crisis intervention skills that every volunteer in a suicide prevention center has. There may even come a day when we can hand out certificates of crisis intervention efficiency to people in the same manner that the Red Cross certifies persons in first-aid proficiency.

Suicide prevention will require a core of highly trained experts to implement programs and train others. Several things will produce these specialists. First, all students in the fields of social work, psychology, and counselling should receive specific training in suicide. Students in these fields currently graduate with little or no knowledge of suicide. This is an unconscionable oversight on the part of university training programs! In addition, each university should be associated with a suicide prevention center where students can receive practicum training, complete internships, and carry out research projects. Finally, students and professors would be encouraged to study suicide if multidisciplinary fellowships in suicidology were made available.

Aside from providing information to helping professionals,and training experts in the field, we must provide information to the general public. A massive public education campaign would serve several purposes. To begin with, the public should be aware of the signs of approaching suicide. A good model for such a program would be the education campaign which has made everyone aware of the signs of cancer. Television, newspapers, radio, advertisements, documentaries, films, and magazine articles can disseminate this information.

There is also a great need for more books on the subject of adolescent suicide. Most of the books currently available pertain to adults - and we have seen that suicidal adolescents are often different from suicidal adults. Public education campaigns will also reduce the myths, prejudice, and stigma associated with suicide.

Where will we find the personnel to provide such a vast array of services? Volunteers and semi-professionals are the answer to this need. Lay persons,carefully selected and trained,can supply excellent services in suicide prevention centers and other suicide programs.[22] They provide warm, direct, and nonauthoritarian contact with the suicidal person. However, we need to improve our methods of recruiting, training, supervising and evaluating them if we wish to make optimal use of this vast resource. We also need to find more innovative ways to use volunteers than sitting them in front of telephones. They are capable of doing more! We especially need to recruit high school students who are willing to help suicidal adolescents.

Of course, any effective prevention program will be based on a firm understanding of suicide. Unfortunately, we know little about this phenomenon. Only a massive funding of high quality research projects will correct this situation.

SUICIDE RESEARCH

There is a pressing need for information about suicide in general, and adolescent suicide in particular. Only research on the psychology, biology, and ecology of suicide can provide this. It is unfortunate that research is seldom done on adolescent suicide because of taboos and myths. For example, Jerry Jacobs, an eminent scholar in the field of suicide, reports that it took him a full year to find a control group of thirty-one adolescents for his "Study of Adolescence."[23] The research concerned suicide but was safe for all involved. However, the school system in question did not want to participate in research even remotely connected with suicide. Jacobs was allowed to proceed only after a year of numerous interviews and meetings. Other researchers of suicide can expect similar obstacles, but they must persevere and not let this stop their research. They should come prepared and proceed, despite the frustrations. Patience, diplomacy, and plentiful time are requirements that any researcher of suicide should cultivate.

We know little about adolescent suicide, and even less about the process of becoming suicidal in the "normal" adolescent. Our knowledge is mostly confined to psychotic, depressed, or hospitalized adolescents. It is time we studied suicidal adolescents in high schools. We also need to know more about the differences between adolescents who merely attempt suicide and those who complete the act. Such differences will have important ramifications for differential prediction, treatment, and prevention. The author's tentative hypothesis concerning these differences are mentioned in Chapter 6. They await research validation before they can be used in any other than a tentative manner. Finally, we must discover how suicidal adolescents differ from suicidal adults.

In addition to studying adolescents, we should know more about suicide in specific groups, such as high school students, college students, the elderly, Eskimos, and Canadian Indians. Questions which must be answered, concern the specific factors and stresses involved in each group's suicide. We must know this to plan therapeutic measures, support systems, and environmental modifications suitable to each group's different needs.

To this point,we have discussed the fact that more and different kinds of research must be done. This research will have to be of higher quality than that which has preceded it. Presently,suicide research exhibits a wide array of inadequacies and methodological problems. The following are suggestions for improving the quality of suicidal research.

Correcting Methods of Investigation

Often suicide research uses the method of residuals.[24] The residual effects of the deceased are used to determine his state when alive. Diaries, personal documents, and the memories of family and friends are all sources. However memories can fail or be colored by guilt. Diaries and documents are of unknown validity. Unfortunately, there are few ways of instituting controls.

Many investigators have turned to the use of substitute subjects, but this, too, has its problems.[25] Here, live survivors of suicide are considered representative of those who have committed suicide,and vice-versa. Those who attempt,or threaten,are thought to exhibit the same behavior,but in lesser quantity. This assumption overlooks the fact that these behaviors differ qualitatively. Thus, the method is both logically and empirically wrong. Future research must carefully define the population studied and make no generalizations to other forms of suicidal behavior. For instance, if adults are studied, the results cannot be generalized to adolescents. If we study those who attempt suicide, we must carefully define their suicide intent and not indiscriminantly generalize their results to those who commit suicide.

Improving Controls

Problems of control occur because of feedback from the suicide attempt, the effects of hospitalization, and inadequate control populations.[26] Feedback from the attempt results when the attempt has a cathartic effect. This complicates matters when subjects are examined after the attempt. The person's responses at this time may not reflect his state prior to the act. This problem is solved if one can find records and test data existing prior to the attempt. Aside from cathartic effects, the physical damage done by the act can effect research results. Lethargy from loss of blood, self-consciousness, depression from disfigurement, brain damage from bullet wounds, etc., all affect results. We need to know about the physical and cathartic effects of attempts in order to set a baseline for future research.

The effects of hospitalization are often overlooked. Suicidal patients are subject to drug treatment, special attention, electroshock, and constant surveillance. This can produce a lessening of symptoms or an increase in guilt and embarrassment. Hospital treatment can create moods, symptoms, and changes not representative of suicidal persons in general. Also, those who are hospitalized may be a special group. It is ludicrous to think that a severely depressed teenager, hospitalized for a highly lethal attempt, is representative of suicidal students in high schools. The former adolescent is hospitalized because of the lethality of his act, or the blatentness of his psychological problems. He does not represent the high school student who is quietly taken to the family physician and never hospitalized. We must begin to study suicidal adolescents in the high school - not the hospital!

Inadequate control populations are also routine in suicide research.[27] Ideally, a control population should be as nonsuicidal as possible. However, control populations are often not chosen with adequate care. There is usually no documentation to prove a previous suicide attempt, and few controls will admit to such past behavior - they then slip through and contaminate the control group. We must control for this by taking a psychiatric background and screening all control group members with psychological tests.[28] Of course, psychopathology does not automatically indicate suicidal predispositions, but this would ensure a "purer" control group.

Better Sampling Procedures

Research on adolescent suicide exhibits many sampling problems. To begin with, samples are often smaller than thirty subjects. Sometimes implications are based upon as few as one to three cases! Samples are also taken from unrepresentative populations, such as neuropsychiatric hospitals. Clearly, it is wrong to generalize these results to suicidal adolescents in high schools.

A final sampling problem occurs when suicidal subjects are inadequately classified and identified. After all, suicide is a term that covers a multitude of experiences and actions. Therefore, we need to carefully define how suicidal our sample is, and what kind of suicidal behavior they are displaying. Otherwise, there is confusion and vagueness when we talk of "suicide." Until this ends, research results will remain unconclusive and often contradictory.

More Complex Research Design

Simplistic statistical tests,such as those currently used,cannot reveal complex relationships between the great number of variables that lead to suicide. Factors of age, sex, socioeconomic status, family background, suicidal intent, etc., all interact to produce suicide. More complex statistical techniques can study a number of variables at one time, as well as define their relationship to one another. Examples of sophisticated techniques include multiple regression, factor analysis, and more complex analysis of variance methods.

Revamping suicide prevention centers, beginning community prevention programs, and improving current research procedures will all help to prevent adolescent suicide. Schools will also have to get involved if we truly wish to halt suicide in the young.

SUICIDE PREVENTION IN THE SCHOOLS

Adolescents spend half their waking hours inside schools. Schools play a large part in the lives of adolescents, and while they do not cause suicide, they frequently contribute to it. As a result, schools must become involved in suicide prevention. They can no longer afford to neglect suicide for the toll of suicidal students is mounting. In addition, each of these students leaves indelible scars on the rest of the student population. If school administrators and counsellors are unaware of this, they only need to talk to students. Most can tell a story of a suicidal classmate they knew and their disturbance at the event is visible to anyone talking to them.

What can schools do to stop suicide? Unfortunately, there are no simple answers. In some cases, prevention requires major changes in curriculum and classroom structure. The only other alternative is to allow students to die at ever increasing rates and blight the lives of those around them. Jerry Jacobs says of the suicidal students in his study:

> If the school personnel had realized the importance of the school to the adolescent in his search for meaningful relationships, and done something to help implement the adolescent's efforts through a system of planned programs, it would have gone a long way towards reducing suicides and suicide attempts among the school age children of this study.[29]

The following are suggestions for reducing suicides in the school.

Suspension Policies

Suspending students from school can be an effective way of dealing with misbehavior, but a critical exception must be made for suicidal students. Frequently the suicidal student has lost friends, and his family relationships are shattered. Often, the only human relationships he has left are found at school. When a suicidal student is suspended, his last human bond is broken. In a state of complete isolation, he may then commit suicide. A principle who suspends a seriously suicidal student is likely signing that student's death warrant! Therefore, it is not an easy decision, and should not be done unless the student's behavior is greatly harming other students. If suspension is necessary, principals and school counsellors should make sure the student is hospitalized,or receiving intensive therapy while out of school.

Some suicidal adolescents do act-out hostility, as we saw in Chapter 6. This means that they probably represent a significant proportion of students requiring administrative discipline. Therefore, school administrators should routinely confer with school therapists concerning suspensions of students. School therapists can let administrators know if the troublesome student has a history of suicide or exhibits signs which warn of suicide.

Fostering a Wide Range of Interests

Alberta school curriculums are very narrow in scope. They breed a concomitant restriction of abilities and interests in students. Some other school boards in Canada are equally guilty of this. Students currently spend half their waking hours being bombarded with impractical, insular, and boring curriculum. Meaninglessness abounds. When only a narrow range of abilities are rewarded, failure and mediocrity are also produced.

Schools should foster creativity through art, music, dance and writing. Creativity is an extremely good way to ventilate self-destructive urges. Curriculums should also be widened to include more interests than the 3 R's. Gifted students, students with special talents, and students with special interests must be more able to fulfill their needs. Currently, students with a flair for languages, a talent in music, or an interest in psychology, have to wait eighteen years of their life before they can study these areas in depth. They must stifle ability and extra interests until university. Many simply give up and accept boredom! Schools are killing special talents, abilities, and interests. Apathy and meaninglessness result.

Community Education

Schools are usually isolated from the communities surrounding them. This produces alienation in students, which contributes to suicide. Community members must be active in the schools and schools must extend education into the community. Work experience programs are one example of how this can be done. Students should be required to research projects in the community as well. For instance, a psychology class can learn about alcohol abuse from a textbook, but this should be supplemented by visits to alcohol treatment centers, guest speakers on the subject, etc.

Ending Age Segregation

Schools must break down age barriers. Students of all ages have much to offer one another. Youngsters need the role model adolescents provide, and adolescents need the experience of caring for and educating the young. The elderly and adolescent also have much to offer one another. Currently, the adolescent is forced into the artificiality of the peer group because he is devoid of relationships with those of other ages. This must end! Students of all ages should study together and high schools should be affiliated with elementary schools and senior citizen homes.

Volunteer Work Experience

Currently, students in schools are useless. They fulfill no essential functions in their society. They cannot help feeling powerless, helpless, and unneeded. This is a breeding ground for suicide! Schools should institute volunteer and work experience programs which earn students credits. Such programs would be tied into theoretical studies and enable students to aid the old and young in day care centers, drug abuse centers, hospitals, senior citizen homes, etc. This would give adolescents a sense of usefulness. They would realize that others do need them and that theoretical knowledge is of practical use.

Ending Loneliness and Impersonality

Schools are impersonal places and isolation produces suicide. Although schools are huge, they can combat impersonality. First, more teachers are needed to reduce student-to-teacher ratios. Second, individual educational programs should be emphasized. Here, the teacher would see students for less time but the one-to-one, or small group setting, would allow closer contact. Individual study should be combined with small group seminars where the contact of teachers and students is close.

Sharing Responsibility

Adolescents should be allowed to participate in the decisions and responsibilities of their schools. They cannot learn to cope with problems unless they are given this opportunity. Students spend their days in school treated like passive cattle,or dangerous children, and are then expected to cope with their lives outside of school! Many do not learn to solve problems. They see suicide as their only way to cope.

An interesting means of combatting this has recently been suggested by the students of Bonnie Doon Composite High School in Edmonton. They requested that students be given representation on administrative councils of the school. The students wish to participate in the democratic process and become involved in the decisions and problem-solving efforts that will affect them. Unless adolescents feel they can solve problems and contribute, hopelessness grows. Where hopelessness exists, suicide cannot be far behind!

The Suicide Consultant

Every school board should employ a person trained in psychology who is also an expert in the area of suicide. This person would be knowledgeable in the areas of education, counselling, psychological testing, and adolescent suicide. He would act as a consultant and resource person to the schools in his district. School administrators, counsellors, psychologists, and teachers could call upon his services when they suspect they have a suicidal student. This expert could also provide suicide workshops to train school personnel in the recognition and handling of suicidal students.

School Psychologists and Counsellors

Schools need to hire more school therapists. Suicide, drug abuse, alcohol abuse, teenage pregnancies, etc., are rampant in schools. This necessitates more counselling staff. This staff should also be better trained in the areas of suicide, drug abuse, alcohol addiction, etc. than they are at present. In fact, therapists intending to work in the school system should have to complete a one-year internship in the area of school counselling.

Above all, counsellors must change their image if they wish troubled students to seek them out. The counsellor will have to display a higher profile and establish more contact with students. Counsellors can meet students by teaching occasional classes. They should also offer interesting and helpful services to attract students. Some of these services include study skills, public speaking, assertiveness, personal growth, and career decision-making groups. University counselling services who offer such groups, find they are well patronized. High school students would be equally appreciative. Above all, such groups give the counsellor an opportunity to establish a relationship with large numbers of students. Thus, when a student is in crisis, he is more likely to think of visiting the counsellor. Many students who enroll in career or study seminars offered by University Counselling Services, return at a later date with their problems. It is almost as if they were using the study skills group to check out the counsellor before they entrust him with personal problems. High school counsellors would be wise to give students similar opportunities to "check them out."

These are only a few of the ways schools can prevent suicide. Hopefully, skilled and innovative school administrators will produce programs of their own. It will not be easy, but certainly the alternative to suicide prevention is even less pleasant.

CONCLUSION

A wide range of suicide prevention programs have been discussed in this chapter. We have looked at suicide prevention centers, community prevention, research, and even school changes which would prevent suicide. All parts of society, from the family to the community at large, must become involved in prevention programs if we wish to end suicide. There are no simple or easy answers here - only effort, innovation, and caring! According to Otto Ulf, suicide prevention must involve the effort,

> to create a society where family and school have reasonable possibilities to offer children and adolescents the opportunity to experience the security, stability, and contact without which too many young people grow up today.[30]

NOTES

1. Ari Kiev, "Suicide Prevention," in Dorothy B. Anderson and Lenora J. McClean (Eds.), Identifying Suicide Potential, New York: Behavioral Publications, Inc., 1971, p. 4.

2. Ibid., p. 5.

3. M. Leah Gorman, "Primary and Secondary Prevention: A Frame of Reference," in Dorothy B. Anderson and Lenora J. McClean (Eds.), op. cit., p. 58.

4. Jane O'Hara, "Young Suicides," Maclean's, 1979, 92(31), 1979, p. 23.

5. Lenora J. McClean, "What can we learn from the low-risk caller to a suicide prevention center?" in Dorothy B. Anderson and Lenora J. McClean (Eds.), op. cit., p. 82.

6. Ibid.

7. Ibid.

8. Ibid.

9. Ibid.

10. Ari Kiev, op. cit., p. 6.

11. Jane O'Hara, op. cit., p. 23.

12. Robert E. Litman, "Experiences in a Suicide Prevention Center," in Jan Waldenström, Tage Larsson, and Nils Ljungstedt (Eds.), Skandia International Symposia: Suicide and Attempted Suicide, Stockholm: Nordiska Bokhandelns Förlag, 1971, p. 229.

13. Ibid.

14. Lenora J. McClean, op. cit., p. 84.

15. Ari Kiev, op. cit., p. 7.

16. Richard Fox, "The Recent Decline of Suicide in Great Britain: The Role of the Samaritan Suicide Movement," in Edwin S. Shneidman (Ed.), Suicidology: Contemporary Developments, New York: Grune and Stratton, 1976, p. 501.

17. Ibid., p. 517.

18. Ibid.

19. Edwin S. Shneidman, "Recent Developments in Suicide Prevention," in Edwin S. Shneidman, Norman L. Farberow, and Robert E. Litman (Eds.), The Psychology of Suicide, New York: Science House, 1970, p. 148.

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24. Charles Neuringer, "Methodological Problems in Suicide Research," Journal of Consulting Psychology, 1962, 26(3), p. 274.

25. Ibid., p. 275.

26. Ibid.

27. Ibid., p. 276.

28. Ibid., p. 273.

29. Jerry Jacobs, op. cit., p. 108.

30. Otto Ulf, "Suicidal Behavior in Childhood and Adolescence," in Jan Waldenström, Tage Larsson, and Nils Ljungstedt (Eds.), op. cit., p. 201.

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